

*SAMHSA*

**GPRA PERFORMANCE PLAN  
FOR FY 2000  
AND  
REVISED FINAL PERFORMANCE PLAN  
FOR FY 1999**

**JANUARY 1999**

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**SAMHSA Measures Summary - FY 2000 GPRA Performance Plan**

This table summarizes and compares, side-by-side, the performance measures from SAMHSA's FY 2000 and FY 1999 GPRA plans. The table also contains information on when baseline data was or will be available; when targets will be determined if baseline data are not now available; and when progress data will be available if it is not now available. In all cases, SAMHSA intends to provide update data on an annual basis.

The first several pages of the table show long-range policy measures, program goal measures, and client outcome measures that were developed in FY 1999 for application across all SAMHSA programs to which they are appropriate. These measures will begin to be applied in FY 1999, generating baseline data in most cases in FY 2000 and update data on an annual basis beginning in FY 2001. Accordingly, all of these common measures are developmental in nature.

The remaining sections of the table show measures for individual SAMHSA programs. These sections also contain some measures developed in the past year which did not appear in the FY 1999 GPRA plan. The table shows these changes.

**SAMHSA Measures - Long Term Policy Goals**

<b>Support and contribute to the improvement of community-based systems of mental health care to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Increase the percentage of adults with serious mental illness who are currently employed or engaged in productive activities; have a permanent place to live in the community; have not had contact with the criminal justice system. Increase the percentage of children with serious emotional disturbances who attend school regularly; reside in a stable environment; and have no contact with the juvenile justice system. Specific targets have not yet been established pending availability of baseline data. <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001  Note: SAMHSA core client outcome measures will be utilized to generate these data.

<b>Educate and enable America's youth to reject illegal drugs as well as underage use of alcohol.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Reverse upward trend and cut monthly marijuana use among 12 to 17-year-olds by 25 percent from the 1995 baseline of 8.2 percent to 6.2 percent by the end of FY 2002. By 2002, reduce the prevalence of past month use of illegal drugs and alcohol by youth by 20 percent as measured against the 1996 base year. By 2007, reduce this prevalence by 50 percent. Reduce tobacco use by youth by 25 percent by 2002 and by 55 percent by 2007. <i>Target:</i> see measures above.	New in FY 2000	Baseline: FY 2000 Targets determined. Update: FY 2001  Note: National baseline data already are available, updated each year. Program-level data will begin to be generated in FY 2000.

<b>Assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
(a) Increase the percentage of adults receiving substance abuse services who are currently employed or engaged in productive activities; had a permanent place to live in the community; had no or reduced involvement with the criminal justice system; experienced no or reduced alcohol or illegal drug related health, behavior, or social consequences, and had no past month substance abuse (Specific targets have not yet been established pending availability of baseline data). By 2007, as compared to the 2001 base year, achieve for those completing substance abuse treatment programs a: 10 percent increase in full time employment (adults); a 10 percent increase in educational status (adolescents); a 10 percent decrease in illegal activity; and a 10 percent increase in general medical health. (b) Reduce the size of the treatment gap, defined as the difference between those seeking treatment and those receiving it. By 2002, reduce the public treatment gap by at least 20 percent as compared to the 1996 base year; by 2007, reduce the gap by at least 50 percent. National data source under consideration in cooperation with ONDCP. SAMHSA will collect program level data. <i>Target for (a):</i> TBD. <i>Target for (B):</i> Consistent with ONDCP PME	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001  Note: SAMHSA core client outcome measures and other program data will be utilized to generate data. A national data source for these measures does not exist at this time.

**SAMHSA Measures - Program Goals**

<b>Goal 1: Bridge the Gap between knowledge and practice.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Increase the percentage of completed knowledge development activities that are recommended for further dissemination as a knowledge application program <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD:FY 2000 Update:FY 2001

<b>Goal 2: Promote the adoption of best practices.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Increase the percentage of completed knowledge application activities that change user practice, or are adopted by users <i>Target: TBD</i>	New in FY 2000	Baseline:FY 2000 Targets TBD: FY 2000 Update: FY 2001

<b>Goal 3: Assure services availability / meet targeted needs</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Increase the percentage of completed targeted capacity expansion activities that assured service availability or otherwise met the identified need. <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Target TBD: FY 2000 Update:FY 2001

<b>Goal 4: Enhance service system performance</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Increase the utility of Federal, State, and local data to enhance service system performance. <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Target TBD:FY 2000 Update:FY 2001

**SAMHSA and Program Level Measures - CORE CLIENT OUTCOMES**

<b>Goal: Increase client outcomes in SAMHSA funded programs</b>		Note: To be applied to all SAMHSA discretionary programs, as appropriate.
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
<u>Substance Abuse Prevention Measures (Children):</u>  Over the past month, the percent of children: a) Using substances declined for those receiving services compared to the national average or project baselines b) Strongly disapproving of substance use increased for those receiving services compared to the national average or project baselines c) Perceiving personal/health risks associated with the consequences of substance abuse increased for those receiving services compared to the national average or project baselines <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
<u>Substance Abuse Prevention Measures (Adults):</u>  Over the past month, the percent of parents/adults: a) Using illegal drugs declined for those receiving services compared to the national average or project baselines. b) Strongly disapproving of substance use increased for those receiving services compared to the national average or project baselines. c) Perceiving personal/health risks associated with the consequences of substance abuse/misuse increased for those receiving services compared to the national average or project baselines. <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
<u>Mental Health and Substance Abuse Treatment Measures (Children):</u>  Over the past year, percent of children/adolescents under age 18 receiving services who: a) were attending school b) were residing in a stable living environment c) had no involvement in the juvenile justice system d) had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds) <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
<u>Mental Health and Substance Abuse Treatment Measures (Adults):</u>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001

<p><b>Goal: Increase client outcomes in SAMHSA funded programs</b></p>	<p>Note: To be applied to all SAMHSA discretionary programs, as appropriate.</p>
<p>Over the past year, percent of adults receiving services increased who:</p> <ul style="list-style-type: none"> <li>a) were currently employed or engaged in productive activities</li> <li>b) had a permanent place to live in the community</li> <li>c) had reduced involvement with the criminal justice system</li> <li>d) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs</li> </ul> <p><i>Target: TBD</i></p>	
<p><u>Additional Measures for Substance Abuse Treatment and Prevention:</u></p> <p>Over the past month, the percent increase of adults receiving services who had no past month use of illegal drugs or misuse of prescription drugs</p> <p><i>Target: TBD</i></p> <p>Over the past month, the percent increase of youth (population data limited to 12-17 year olds) receiving services who experienced no substance abuse related health, behavior, or social consequences</p> <p><i>Target: TBD</i></p>	<p>New in FY 2000</p> <p>Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001</p>

**SAMHSA Program Goal 3: Assure Services Availability /  
Meet Targeted Needs**

**Program Level Measures - Block Grants**

<b>CMHS Community Mental Health Services Block Grant</b>		FY 1997 Actual: \$275,420,000 FY 1998 Actual: \$275,420,000 FY 1999 Enacted: \$288,816,000 FY 2000 Estimate: \$358,816,000
<b>Goal: To improve community based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase % of adults with serious mental illness who are employed, are living independently, and have had no contact with the criminal justice system. Increase % of children with serious emotional disturbance who attend school regularly, reside in a stable environment, and have no contact with the juvenile justice system. <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 2. Ten States will pilot 28 performance indicators <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
	Measure 1. Increase satisfaction with technical assistance to 80%	Dropped
	Measure 2. Increase to 80% the proportion of States that utilize common definitions and data collection approaches	Dropped

<b>CSAP Substance Abuse Prevention Set-aside From SAPT Block Grant</b>		FY 1997 Actual: \$248,920,000 FY 1998 Actual: \$248,920,000 FY 1999 Enacted: \$301,150,000 FY 2000 Estimate: \$306,850,000
<b>Goal: To expand and enhance substance abuse prevention services</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>

<b>CSAP Substance Abuse Prevention Set-aside From SAPT Block Grant</b> <b>Goal: To expand and enhance substance abuse prevention services</b>		FY 1997 Actual: \$248,920,000 FY 1998 Actual: \$248,920,000 FY 1999 Enacted: \$301,150,000 FY 2000 Estimate: \$306,850,000
Measure 1. Increase % of States that incorporate needs assessment data into block grant application <i>Target: TBD</i>	Was Measure 3. Similar to FY 2000. Tentative target was 45%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 2. Increase % of States that use funds in each of 6 prevention strategy areas <i>Target: TBD</i>	Was Measure 1. Same as FY 2000. Tentative target was 80%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 3. Maintain satisfaction with TA <i>Target: 90%</i>	Was Measure 5. Same measure and target as FY 2000.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 4. Identify and complete testing of prevention performance outcome measures <i>Target: 5 outcome measures tested in 11 States</i>	Was Measure 6. Same measure and target as FY 2000.	Baseline: FY 1998 Targets Determined. Update: Annually
	Measure 2. 30% of States use 20% of grant to fund community mobilization and empowerment strategies	Dropped
	Measure 4. 30% of States use validated and standardized measure for States=prevention program	Dropped

<b>CSAT Substance Abuse Prevention and Treatment Block Grant</b> <b>Goal: To support prevention and treatment service</b>		FY 1998 Actual: \$1,310,107,000 FY 1999 Enacted: \$1,585,000,000 FY 2000 Estimate: \$1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Outcome indicators will be reported voluntarily as part of FY 2000 block grant application	New in FY 2000	Baseline: FY 2001 Targets TBD: FY 2001 Update: FY 2002

<b>CSAT Substance Abuse Prevention and Treatment Block Grant</b>  <b>Goal: To support prevention and treatment service</b>		FY 1998 Actual: \$1,310,107,000 FY 1999 Enacted: \$1,585,000,000 FY 2000 Estimate: \$1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)
Over the past year, percent of adults receiving services increased who: a. were currently employed or engaged in productive activities b. had a permanent place to live in the community c. had no/reduced involvement with the criminal justice system d. experience no/reduced alcohol or illegal drug related health, behavior, or social consequences, e. had no past month substance abuse  Over the past year, percent of children/ adolescents under age 18 receiving services increased who: a. were attending school b. were residing in a stable living environment c. had no/reduced involvement in the juvenile justice system d. had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds), e. experienced no/reduced substance abuse related health, behavior, or social consequences <i>Target: TBD</i>		
Measure 2. Develop and implement performance outcome measures for SAPT block grant <i>Target: TBD</i>	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 3. Increase % of States that express satisfaction with TA provided <i>Target: TBD</i>	Was Measure 4. Same as FY 2000. Tentative target: 85%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 4. Increase % of TA events that result in systems, program or practice change <i>Target: TBD</i>	Was Measure 5. Same as FY 2000. Tentative target: 50%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
	Measure 1: Increase to 75% the proportion of BG applications received electronically	Dropped
	Measure 2: Increase to 80% the proportion of BG applications	Dropped

<b>CSAT Substance Abuse Prevention and Treatment Block Grant</b>  <b>Goal: To support prevention and treatment service</b>		FY 1998 Actual: \$1,310,107,000 FY 1999 Enacted: \$1,585,000,000 FY 2000 Estimate: \$1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)
	which include needs assessment data from CSAT's needs assessment program	
	Measure 3: Identify and pilot 7 treatment outcome measures in 7 States	Dropped

<b>CMHS Children's Mental Health</b>  <b>Goal: To improve outcomes for children and their families by implementing systems of care for children serious emotional disturbance.</b>		FY 1997 Actual: \$69,896,000 FY 1998 Actual: \$72,927,000 FY 1999 Enacted: \$78,000,000 FY 2000 Estimate: \$78,000,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase Interagency collaboration: -Referrals from non-MH agencies for MH services will increase <i>Target: 10%</i> -Referrals from juvenile justice programs will increase  <i>Target: 12%</i> -Case records that reflect cross-agency treatment planning will increase <i>Target: 10%</i>	Same as FY 2000. Target for each element was 5%.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Decrease utilization of Inpatient/residential treatment (avg days in facility) <i>Target: 20% of FY 1997 baseline</i>	Same as FY 2000. Target was 20%.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 3. Children's outcomes: -Increase the number of children attending school 75% of the time <i>Target: 10%</i> -Increase the number of children with law enforcements contacts at entry who have no law enforcement contacts after 6 months <i>Target: 57%</i>	Was Measures 3 & 4. Target was 10% for school attendance. Measure for law enforcement was to increase referrals from Juvenile Justice by 10%.	Baseline: FY 1997 Targets Determined. Update: Annually  Note: Revised FY 2000 measure for law enforcement better captures the outcome.
Measure 4. Increase level of family satisfaction with services <i>Target: 10% over FY 1997 baseline</i>	Was Measure 5. Same as FY 2000. Target unchanged.	Baseline: FY 1997 Targets Determined.: Update: Annually
Measure 5. Increase stability of living arrangements by decreasing the number of children having more than one living arrangement within 6 months <i>Target: 25% over FY 1997 baseline</i>	Was Measure 6. Target was 10%.	Baseline: FY 1997 Targets Determined. Update: Annually

<b>CMHS Protection and Advocacy</b>		FY 1997 Actual: \$21,957,000 FY 1998 Actual: \$21,957,000 FY 1999 Enacted: \$22,957,000 FY 2000 Estimate: \$22,957,000
<b>Goal: Through advocacy activities, to reduce incident of abuse, neglect, and civil rights violations of individuals with mental illness in residential facilities.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. At least 9,000 complaints of abuse will be addressed by State PAIMI systems <i>Target: 9,000</i>	New in FY 2000.	Baseline: FY 1997 Target determined. Update: Annually
Measure 2. Maintain the number of individuals attending public education and training activities and public awareness activities <i>Target: 160,000</i>	Same as FY 2000. FY 1999 target revised based on baseline data. Original FY 1999 target: 120,000; revised FY 1999 target 160,000.	Baseline: FY 1996 Targets determined. Update: Annually
Measure 3. Maintain the percentage of priorities and goals that have made substantial progress <i>Target: 70%</i>	Same as FY 2000. Same target.	Baseline: FY 1997 Targets determined. Update: Annually
Measure 4. Increase the number of substantiated incidents of abuse, neglect or rights violations reported by clients which are favorably resolved <i>Target: TBD</i>	Same as FY 2000. Tentative target was 55%.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001

<b>CMHS PATH Homeless Formula Grants</b>		FY 1997 Actual: \$20,000,000 FY 1998 Actual: \$23,000,000 FY 1999 Enacted: \$26,000,000 FY 2000 Estimate: \$31,000,000
<b>Goal: To provide services to enable persons who are homeless and have serious mental illness to be placed in appropriate housing situation and to engage them with formal mental health treatment and systems</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase to 115,000 the number of persons contacted relative to population in need <i>Target: 115,000/600,000</i>	Same as FY 2000. FY 1999 target has been revised upward from 92,000 to 102,000 based upon latest data.	Baseline: FY 1996 Targets Determined. Update: Annually
Measure 2. Increase the percentage of participating agencies that offer outreach services <i>Target: 80%</i>	Same as FY 2000, with a target of 70%	Baseline: FY 1996 Targets Determined. Update: Annually
Measure 3. Maintain the percentage of persons contacted who become enrolled clients at 30% or greater <i>Target: 33%</i>	Same as FY 2000, with a target of 30%	Baseline: FY 1996 Targets Determined. Update: Annually

<b>CSAP State Incentive Grants (SIG)</b>		FY 1997 Actual: \$15,000,000 FY 1998 Enacted: \$55,993,000 FY 1999 Enacted: \$61,652,000 FY 2000 Estimate: \$61,652,000
<b>Goal: Assist Governors to coordinate, leverage and/or redirect all substance abuse prevention resources; develop strategy to reduce drug use by youth</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase State collaboration rating <i>Target: TBD</i>	New in FY 2000	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 2. Decrease past month substance use for youth 12-17 <i>Target: 15% reduction</i>	New in FY 2000	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000

<b>CSAP Community Coalition Program</b>		FY 1997 Actual: \$36,171,000 FY 1998 Actual: \$ 8,318,000 FY 1999 Enacted: \$ 6,422,000 FY 2000 Estimate: \$ 473,000
<b>Goal: To increase community involvement in dealing with problems of substance abuse and its attendant effects; to promote the development of infrastructure in communities for initiating and facilitating substance abuse prevention activities</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Project completed. Two measures repeated in FY 2000 performance plan. Final reporting should occur in the FY 2001 plan, after which this program will drop from the plan/report.	Measure 1. Increase the mean number of organizations participating in coalition activities <i>Target: 40%</i>	Baseline: FY 1995 Targets Determined. Final data available: FY 1999
	Measure 2. Increase prevention services that promote coalition efforts <i>Target: 100%</i>	Baseline: FY 1998 Targets Determined. Final data available: FY 1999
	Measure 3. Number of volunteer hours	Dropped

<b>CSAP Synar Amendment (Section 1926) Implementation</b>		FY 1997 Actual: \$1,350,000 FY 1998 Actual: \$1,400,000 FY 1999 Enacted: \$1,300,000 FY 2000 Estimate: \$1,500,000
<b>Goal: To reduce the sales rate of tobacco products to minors in all States</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase number of States whose rates of tobacco sales to minors violations is at or below 20% <i>Target: 12 States</i>	Was measure 3. Same as FY 2000. Target was 8 States.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Maintain periodic technical assistance for implementation of guidelines <i>Target: 100%</i>	Same as FY 2000. Target was to increase to 100%	Baseline: FY 1997 Targets Determined. Update: Annually
	Measure 1. Develop measure of violation rate	Dropped

<b>CSAT Targeted Capacity Expansion</b>		FY 1998 Actual: \$24,732,000 FY 1999 Enacted: \$55,232,000 FY 2000 Estimate: \$110,232,000
<b>Goal: To address gaps in treatment capacity</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase the proportion of clients served <i>Target: TBD</i>	Program first reported in FY 2000.	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 2. SAMHSA core measures (Adults and Adolescents: employed or in school; permanent living; reduced involvement with the criminal justice system; no substance abuse related health, behavior or social consequences) <i>Target: TBD</i>	Program first reported in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001

## SAMHSA Goals 1 and 2

### Program Level Measures - Knowledge Development and Application

Note: This program consists of many relatively small Knowledge Development and Application activities. Therefore, only selected examples are shown in the GPRA Performance Plan.

<b>CMHS ACCESS (Knowledge Development)</b>		FY 1997 Actual: \$19,568,000 FY 1998 Actual: \$1,891,000 FY 1999 Enacted: \$1,600,000 FY 2000 Estimate: \$ 450,000
<b>Goal: To examine the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Level of systems integration <i>Target: .74</i>	Was Measure 2 (slight rewording). Same target.	Baseline: FY 1994 Targets Determined. Update: Biennially
Measure 2. Client outcomes for days housed, days of drug use, number of days in outpatient psychiatric services, and percentage committing a minor crime. <i>Targets: Cohort 4 shows equal or greater improvement than the previous cohorts.</i>	Was Measure 3. Same as FY 2000 (slight rewording) <i>Target: &gt; cohort 3</i>	Baseline: FY 1996 Targets Determined. Update: 4th cohort available in late 1999
	Measure 1. 100% implementation of integration strategies	Dropped (completed)

<b>CMHS Employment Intervention Demonstration Program(EIDP)</b>		FY 1997 Actual: \$4,840,000
<b>Goal: Development of the most effective approaches for enhancing competitive employment for adults with severe mental illness</b>		FY 1998 Actual: \$4,749,000
		FY 1999 Enacted: \$3,942,000
		FY 2000 Estimate: 0
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Employment outcomes <i>Target: TBD</i>	Was Measure 2. Same as FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
Measure 2. Development of direct costs for various models <i>Target: TBD</i>	New in FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
	Measure 1. Fidelity assessment	Dropped

<b>CMHS Knowledge Exchange Network (KEN)</b> (Knowledge Application)		FY 1997 Actual: \$ 453,421
<b>Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researcher</b>		FY 1998 Actual: \$1,158,611
		FY 1999 Enacted: \$1,190,814
		FY 2000 Estimate: \$1,500,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase usefulness of KEN information <i>Target: TBD</i>	Same as FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 2. Increase number of requests for brochures information kits & publications; connects to web telephone inquiries <i>Target: 10% increase each year</i>	Same as FY 2000. (Target was a 10% increase over previous year)	Baseline: FY 1998 Targets Determined. Update: Annually

<b>CMHS Community Action Grants for Service Systems Change</b> (Knowledge Application)		FY 1997 Actual: \$2,474,000 FY 1998 Actual: \$ 3,129,000 FY 1999 Enacted: \$ 3,000,000 FY 2000 Estimate: \$ 4,500,000
<b>Goal: To identify exemplary practices for mental health services to persons with serious mental illness and to accomplish adoption of such practices in as many communities as possible</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Phase I grantees achieve consensus and move toward adoption of an exemplary practice. Grantees have appropriate process data <i>Target: 50%</i>	Was Measure 2. Same as FY 2000. Same target.	Baseline: FY 1998 Target Determined. Update: Annually.
Measure 2: Exemplary practices funded in Phase I grants are adopted in Phase II grants <i>Target: 50%</i>	Was Measure 3. Same as FY 2000. Same target.	Baseline: FY 1999 Target Determined. Update: Annually
	Measure 1. 50 applicants identify & justify an exemplary practice or program that meets CMHS criteria	Dropped

<b>CSAP Predictor Variables</b> (Knowledge Development)		FY 1997 Actual: \$5,700,000 FY 1998 Actual: \$5,708,000 FY 1999 Enacted: \$2,561,000 FY 2000 Estimate: \$ 0
<b>Goals: Generate new knowledge about effective approaches.</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Implement effective models <i>Target: 80% of sites</i> Note: This program has been completed and will be reported fully in the FY 2001 plan.	Was Measure 2. Same as FY 2000.	Baseline: FY 1998 Target Determined. Final Data Available: FY 2000
Measure 2. For children 9+, decrease in use of alcohol, tobacco, & drug use compared to children in comparison group <i>Target: TBD</i> (Analysis of data collected in 1997 and 1998 is not yet complete).	Was Measure 3. Same as FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
	Measure 1: All sites will collect data on predictor variables	Dropped

<b>CSAP Starting Early/Starting Smart: Early Childhood Collaboration Project (SESS)</b> (Knowledge Development) <b>Goal: To test the effectiveness of integrating mental health and substance abuse prevention and treatment services, for children ages birth to seven years and their families/care givers, with primary health care service settings or early childhood service settings.</b>		FY 1997 Actual: \$6,200,000 FY 1998 Actual: \$8,277,000 FY 1999 Enacted: \$7,986,000 FY 2000 Estimate: \$7,422,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. SAMHSA and partners execute Memoranda of Understanding <i>Target: 100%</i>	Same as FY 2000. Target expected to be achieved.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Establish baseline data (Physical health, behavior, social and emotional functioning, language development) <i>Target: TBD</i>	New in FY 2000. Once baselines are established, this will be a measure to report outcomes.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
	Measure 2. Report preliminary process and outcome findings	Dropped

<b>CSAP Youth Connect - High Risk Youth</b> (Knowledge Development) <b>Goal: Prevent or reduce substance abuse by improving school bonding and academic performance, family bonding and functioning, and life management skills</b>		FY 1998 Actual: \$6,000,000 FY 1999 Enacted: \$7,000,000 FY 2000 Estimate: \$7,000,000  <b>Note that this program is funded from the High Risk Youth budget activity.</b>
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Decrease substance abuse and related violence for treatment subjects relative to similar population without prevention programming <i>Tentative Target: 10%</i>	Program first included in FY 2000 plan.	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 2. Sites will document models that are determined to be both effective and replicable <i>Tentative Target: 60%</i>	Program first included in FY 2000 plan.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001

<b>CSAP Managed Care Workplace Substance Abuse Prevention Initiatives</b> (Knowledge Development)  <b>Goal: To determine which workplace substance abuse prevention and early intervention programs are the most effective in reducing the incidence and prevalence of substance abuse</b>	FY 1997 Actual: \$4,500,000 FY 1998 Actual: \$4,594,000 FY 1999 Enacted: \$4,672,000 FY 2000 Estimate: 0
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<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Reach agreement in FY 1999 on core process and outcome measures for cross site analysis <i>Target: 100%</i>	Program first included in FY 2000 plan.	Baseline: FY 1998 Target Determined. Update: FY 1999
Measure 2: Health care utilization will increase as defined by pre-post intervention in prospective studies <i>Target: TBD</i>	Program first included in FY 2000 plan.	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2000

<b>CSAP Clearinghouse Program (NCADI)</b> (Knowledge Application)  <b>Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researchers</b>	FY 1998 Actual: \$9,162,000 FY 1999 Enacted: \$2,023,000 FY 2000 Estimate: \$4,729,000	
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Increase number of information requests - phone, mail, Prevlene, walk-ins <i>Target: 10% over FY 1997 baseline</i>	Measure 1 (slightly reworded. Target was 5% over 1997 baseline.	Baseline: FY 1997 Target Determined. Update: Annually
Measure 1. Maintain Customer satisfaction <i>Target: 85%</i>	Measure 3 (slightly reworded). Same target.	Baseline: FY 1997 Target Determined. Update: Annually.
	Measure 2: Increase distribution of hard copy and electronic items	Dropped

<b>CSAP Media - National Public Education/YSAPI</b> (Knowledge Application)		FY 1997 Actual: \$1,000,000 FY 1998 Actual: \$0 FY 1999 Enacted: \$0 FY 2000 Estimate: \$0
<b>Goal: To raise public awareness about substance abuse prevention issues, and to promote healthy changes in individual and group attitudes and behavior</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Media placements & media access <i>Target: 5% over 1997 baseline</i>	Previously reported as separate YSAPI section. Same as FY 2000. Same target.	Baseline: FY 1997 Target Determined. Update: Annually.

<b>CSAP Centers for the Application of Prevention Technologies</b> (Knowledge Application)		FY 1997 Actual: \$5,200,000 FY 1998 Actual: \$6,410,000 FY 1999 Enacted: \$6,449,000 FY 2000 Estimate: \$6,449,000
<b>Goal: To increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their subrecipients</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Increase the number of technical assistance contact hours and an increase in the number of prevention technologies introduced to all SIGS & their subrecipients <i>Target: 25% increase</i>	First included in FY 2000 plan.	Baseline: FY 1998 Target Determined. Update: Annually
Measure 2: Past month substance use will decrease among youth 12-17 years old <i>Target: 15% decline from baseline</i>	First included in FY 2000 plan (YSAPI measure).	Baseline: FY 1997 Target Determined. Update: Annually.

<b>CSAT Treating Adult Marijuana Users</b> (Knowledge Development) <b>Goal: To enhance knowledge about treating adult marijuana users</b>		FY 1997 Actual: \$1,300,000 FY 1997 Actual: \$1,680,000 FY 1998 Actual: \$1,844,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Submit two clinical intervention manuals with lessons learned <i>Target: 2 manuals</i>	Was Measure 4. Same as FY 2000.	Baseline: FY 1997 Target Determined. Update: FY 1999
Measure 2: Clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks <i>Target: TBD</i>	New in FY 2000.	Baseline: FY 1999 Target TBD: FY 2000 Update: FY 2001
	Measure 1. Final protocols from 100% of sites	Dropped
	Measure 2. Complete intervention & final data collection at 100% of sites	Dropped
	Measure 3. Sites will conduct and submit data analysis	Dropped

<b>CSAT Wraparound Services for Clients in Nonresidential Programs</b> (Knowledge Development) <b>Goal: To enhance knowledge about the effects on outcomes of providing wrap around services (e.g.,child care, transportation, educational services)</b>		FY 1996 Actual: \$1,200,000 FY 1997 Actual: \$2,339,000 FY 1998 Actual: \$2,005,000 FY 1999 Enacted: 0
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Coordinating Center will develop and apply statistical models <i>Target: TBD</i>	Was Measure 3. Same as FY 2000.	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2001
Measure 2. Final reports with findings, documented databases and statistical models are transmitted to CSAT, results validated <i>Target: 100% of final reports</i>	Was Measure 4. Same as FY 2000.	Baseline: FY 1996 Target determined. Update: FY 2001
Measure 3. Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone <i>Target: TBD</i>	New in FY 2000.	Baseline: FY 2000 Target TBD: FY 2000 Update: FY 2001
	Measure 1. Finalize protocol for collecting data, conducting data analysis, etc.	Dropped
	Measure 2. Complete observation study and final data collection at all clinical sites	Dropped

<b>CSAT Treating Teen Marijuana Users</b> (Knowledge Development) <b>Goal: To enhance knowledge about treating teen marijuana users</b>		FY 1997 Actual: \$1,950,000 FY 1998 Actual: \$3,200,000 FY 1999 Enacted: \$3,200,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Clients treated with all five models will have significantly reduced marijuana use but none of the treatment will be more effective than the others <i>Target: TBD</i>	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update:FY 2000

<b>CSAT Addiction Technology Transfer Centers</b> (Knowledge Application)		FY 1998 Actual: \$7,545,000 FY 1999 Enacted: \$7,545,000 FY 2000 Estimate: \$7,545,000
<b>Goals: Promote the adoption of best practices</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1. Individuals trained per year <i>Target: 12,000</i>	New in FY 2000	Baseline: FY 1997 Target Determined. Update: Annually
Measure 2. Develop and implement nationally recognized standards for education and training professionals <i>Target: All States adopt standard by FY 2002</i>	New in FY 2000	Baseline: FY 1998 Target Determined. Update: Annually.

<b>OMC Managed Care Activities</b> (Knowledge Development and Application)		Funding is derived from the Knowledge Development and Application budget activity.
<b>Goal: Promote the availability of effective services to persons enrolled in managed care</b>		
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Publication of reports on managed mental health and substance abuse services <i>Target: 9 reports</i>	Same as FY 2000	Baseline: FY 1998 Target Determined. Update: Annually
Measure 2. Provide training on managed mental health and substance abuse issues <i>Target: 80% satisfaction with training</i>	New in FY 2000	Baseline: FY 1998 Target Determined. Update: Annually
Measure 3. Reported satisfaction with their involvement in Managed Care procurement, contracting and monitoring <i>Target: 10 States</i>	Was Measure 2. Same as FY 2000	Baseline: FY 1999 Target Determined. Update: Annually
Measure 4. Release and use of detailed managed mental health and substance abuse quality management and accreditation guidelines <i>Target: 1/2 of the States negotiating Medicaid managed care contracts</i>	New in FY 2000	Baseline: FY 1998 Target Determined. Update: Annually

## SAMHSA GOAL 4

### Program Level Measures - Data

<b>OAS National Household Survey on Drug Use (NHSD)</b>  <b>Goal: To provide estimates of the prevalence of substance abuse at the national level and in the 50 States and the District of Columbia</b>		FY 1997 Actual: \$16,792,000 FY 1998 Actual: \$10,000,000 FY 1999 Enacted: \$26,881,000 FY 2000 Estimate: \$43,343,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Availability of data collection system in calendar year 1999 <i>Target: 1999</i>	Same as FY 2000	Baseline: FY 1999 Target Determined. Update: FY 2000
Measure 2: Availability and timeliness of data in calendar year 2000 <i>Target: 2000</i>	Same as FY 2000	Baseline: FY 2000 Target Determined. Update: FY 2001

<b>OAS Drug Abuse Warning Network (DAWN)</b>  <b>Goal: To provide estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas</b>		FY 1997 Actual: \$2,771,000 FY 1998 Actual: \$5,936,000 FY 1999 Enacted: \$5,401,000 FY 2000 Estimate: \$6,646,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Availability and timeliness of data <i>Target: TBD</i>	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2000

<b>OAS Drug Abuse Services Information System (DASIS)</b>  <b>Goal: To provide information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment</b>		FY 1997 Actual: \$5,515,000 FY 1998 Actual: \$6,860,000 FY 1999 Enacted: \$7,586,000 FY 2000 Estimate: \$9,301,000
<i>FY 2000 Measures:</i>	<i>FY 1999 Measures:</i>	<i>Status:</i>
Measure 1: Availability and timeliness of data <i>Target: TBD</i>	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2000

## Part I - Agency Performance Plan

The Substance Abuse and Mental Health Services Administration (SAMHSA) was created on October 1, 1992. According to its authorizing legislation, the purpose of the agency is to establish and implement a comprehensive program to improve the provision of treatment and related services to individuals with respect to substance abuse and mental illness, and to improve prevention services, promote mental health and protect the legal rights of individuals with mental illnesses and individuals who are substance abusers. The purpose of the reorganization was to create a focus on and enhance substance abuse and mental health services programs and activities. The mission set out in the legislation was broad. However, the array of programs that the new agency inherited addressed only a part of that mission, and the budgetary climate was austere at all levels of government - Federal, State, and local.

In 1996, SAMHSA published its strategic vision, including the following mission statement:

**SAMHSA's mission within the Nation's health system is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.**

Significant accomplishments of SAMHSA's components may be found in each section of the budget narrative.

### Relationship to the HHS Strategic Plan

SAMHSA's programs support all of the goals of the Department of Health and Human Services Strategic Plan. SAMHSA also is responsible for the FY 1999 Secretarial initiative, Prevent Youth Substance Abuse, and contributes to all other Secretarial initiatives. Some of the ways in which SAMHSA contributes to the goals of the HHS Strategic Plan are as follows:

**Reduce the Major Threats to the Health and Productivity of All Americans (Goal 1):** SAMHSA's substance abuse prevention and treatment activities, both through the block grants and the KD&As, directly advance the achievement of strategic objectives under Goal 1 to curb alcohol abuse (1.4) and reduce the illicit use of drugs (1.5).

**Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States (Goal 2):** SAMHSA programs, including the Children's Mental Health Program and the Starting Early/Starting Smart Program, (SESS) clearly contribute to the achievement of Goal 2.

**Improve Access to Health Services and Ensure the Integrity of the Nation's Health Entitlement and Safety Net Programs (Goal 3):** By supporting States in identifying and addressing substance abuse and mental health needs through the block grants -- and in reporting on their performance through a common set of performance measures, SAMHSA promotes not only the accomplishment of Goal 3, but also intergovernmental performance-based accountability.

**Improve the Quality of Health Care and Human Services (Goal 4):** SAMHSA's KD&A-funded models for substance abuse and mental health treatment improve the quality of a critical aspect of comprehensive and needed health care

for Americans.

**Improve Public Health Systems (Goal 5):** SAMHSA's investments in improved national and state data systems, including performance data, and its support for workforce training directly improve public health systems in the United States.

**Strengthen the Nation's Health Sciences Research Enterprise and Enhance its Productivity (Goal 6):** SAMHSA's population-based and services research on substance abuse and mental health issues directly contribute to our Nation's health sciences research enterprise.

### **Long-Term Policy Goals**

Three long-term policy goals summarize SAMHSA's fundamental mission. Goals and performance indicators are drawn from SAMHSA's proposed client outcome measures; from the ONDCP Performance Measures of Effectiveness (PME); and from the draft Healthy People 2010. SAMHSA will continue to support all of the long-term goals of the PME and Healthy People 2010 which relate to SAMHSA's programs.

**Support and contribute to the improvement of community-based systems of mental health care to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.**

Performance Indicators: Increase the percentage of adults with serious mental illness who are currently employed or engaged in productive activities; have a permanent place to live in the community; have not had contact with the criminal justice system. Increase the percentage of children with serious emotional disturbances who attend school regularly; reside in a stable environment; and have no contact with the juvenile justice system. Specific targets have not yet been established pending availability of baseline data.

**Educate and enable America's youth to reject illegal drugs as well as underage use of alcohol.**

Performance Indicators: Reverse the upward trend and cut monthly marijuana use among 12 to 17-year-olds by 25 percent, from the 1995 baseline of 8.2 percent to 6.2 percent by the end of FY 2002. By 2002, reduce the prevalence of past month use of illegal drugs and alcohol by youth by 20 percent as measured against the 1996 base year. By 2007, reduce this prevalence by 50 percent. Reduce tobacco use by youth by 25 percent by 2002 and by 55 percent by 2007.

**Assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts.**

Performance Indicators:

(a) Increase the percentage of adults receiving substance abuse services who are currently employed or engaged in productive activities; had a permanent place to live in the community; had no or reduced involvement with the criminal justice system; experienced no or reduced alcohol or illegal drug related health, behavior, or social consequences, and had no past month substance abuse (Specific targets have not yet been established pending availability of baseline data). By 2007, as compared to the 2001 base year, achieve for those completing substance abuse treatment programs a: 10 percent increase in full time employment (adults); a 10 percent increase in educational status (adolescents); a 10 percent decrease in illegal activity; and a 10 percent increase in general medical health.

(b) Reduce the size of the treatment gap, defined as the difference between those seeking treatment and those receiving it. By 2002, reduce the public treatment gap by at least 20 percent as compared to the 1996 base year; by 2007, reduce the gap by at least 50 percent. National data source under consideration in cooperation with ONDCP. SAMHSA will collect program level data.

SAMHSA has been fully involved in the PME effort. SAMHSA provides direct programmatic support to Goals 1 and 3 of the National Drug Control Strategy and the PME effort, and contributes to Goal 2. SAMHSA has participated in the development of the PME system for the Strategy, chairing or co-chairing each working group for every objective

of Goal 1 and Goal 3, and participating in Goal 2 working groups. In addition to developmental and programmatic support, SAMHSA provides tracking data for many of the objectives of the Strategy. Refining measures, developing strategies, identifying data sources, and setting annual targets are now under discussion.

SAMHSA is the lead agency, with the National Institutes of Health, for the Substance Abuse chapter of the HHS Healthy People 2010, and for the Mental Health and Mental Disorders chapter. The draft Healthy People 2010 document is undergoing revisions prior to its completion later this year.

For SAMHSA's three long-range goals and for the goals and objectives of the PME effort and Healthy People 2010, the intent is to establish, maintain, and if possible to accelerate a trend toward a desired target, not to set specific annual targets. Results in any one year are considered less significant than the cumulative result. In the context of the National Drug Control Strategy, the process of establishing targets under these circumstances is conceptualized as determining the glide path. Moreover, since (1) these long-range goals represent a national effort, (2) SAMHSA is allocated only a portion of the dollars needed to address these problems, and (3) there are many factors influencing the outcomes other than SAMHSA's programs, the agency can influence only a portion of the national outcomes.

### **Program Goals**

Over the nearly six years since its creation as a services agency, SAMHSA has worked to develop and implement a program and budget structure that is consistent with its legislatively defined mission. For FY 2000 and beyond, SAMHSA has identified four key program/operational goals, directly related to current and proposed activities and programs, which summarize the contributions SAMHSA can make to the achievement of the broader national objectives. Unlike the long-term policy goals, these operational goals reflect the outcomes of SAMHSA's programmatic activities. The four goals unite SAMHSA's activities, allocation of resources, budget request, and GPRA performance plan. They provide a logical framework for SAMHSA's spectrum of programs, and are useful in developing measures for new programs.

#### **Goal 1. Bridge the gap between knowledge and practice.**

Relevant Budget Lines: Knowledge Development and Application; High Risk Youth

Performance Indicators: Prospective measures of these activities include the field's judgment that the proposed activities are important and useful. Retrospective measures include evaluation of the quality of the products developed. A final measure of success is the significance of the results, and whether they warrant further dissemination.

SAMHSA's legislative mandate includes conducting and coordinating demonstration projects, evaluations, service system assessments, and other activities necessary to improve the availability and quality of services. SAMHSA was established as a separate services agency in part because a variety of constituent groups perceived a need to establish a firmer link between findings developed through research programs, tested in relatively controlled environments, and the actual needs of providers, clients, and families at the point of service. In 1995, when SAMHSA held meetings around the country with providers, clients/consumers, families, and State and local officials to obtain input on strategic priorities, this issue was emphasized repeatedly as one that should be given particular priority within the agency. Providers and clients need enough information to ascertain whether a possible improvement will work in their service setting in their client population, and to determine how to go about implementing that improvement. SAMHSA's knowledge development programs contribute to this transfer of knowledge from research into practice, in support of the agency's services mission. The important state-of-the-art knowledge derived from these studies can have a substantial impact on client outcomes when the knowledge is disseminated and adopted.

An example of this type of program is the ACCESS program in CMHS, which has examined the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill and on improving outcomes for this population. The program was initiated in 1993 as a five-year study. While final data are not yet

available, two cohorts of available data show increases for the clients served within the study in number of days housed; decreases in drug use; increases in number of days in outpatient settings; and decreases in the percentage committing a minor crime. Indications at this point are that this knowledge development program will produce significant results which will warrant further dissemination.

## **Goal 2. Promote the adoption of best practices.**

Relevant Budget Line: Knowledge Development and Application

Performance Indicators: These activities are to be assessed, through a sampling strategy, according to changes in user practice and adoption by users.

Publication of new findings often is insufficient to change practice. To promote the adoption of best practices, SAMHSA will distribute information strategically to enhance services in communities. In addition, a variety of incentives and assistance will be provided to States, local communities, and providers. These activities help to ensure that service providers have the opportunity to implement important findings. Along with SAMHSA's knowledge development activities, this knowledge application investment contributes toward SAMHSA's legislative mission to improve, as well as to support, services.

An example of this type of program is the CMHS Community Action Grants (CAG) Program. This program supports adoption of exemplary mental health practices through the identification of evidence-based models that may be selected by local communities for adoption into their local systems of care. CAGs identify Exemplary Practice Models that meet objective, evidenced-based-criteria and support consensus building among key stakeholders to adopt the exemplary practice. Information about these approved exemplary practices is then made available to new sponsors of exemplary practices in other communities

## **Goal 3. Assure services availability / meet targeted needs**

Relevant Budget Lines: Targeted Capacity Expansion; Children's Mental Health Services; Substance Abuse Prevention and Treatment Block Grant; Community Mental Health Services Block Grant; Protection and Advocacy for Individuals with Mental Illnesses; and Projects for Assistance in Transition from Homelessness.

Performance Indicators: Results of Targeted Capacity Expansion activities are to be assessed with respect to changes in practice and client outcomes. Measures are being developed and refined by SAMHSA and the States for application to the block grants. Measures for the two formula grants already are in place, and are contained in the CMHS section of this performance plan.

Most of SAMHSA's funding is invested in Goal 3 activities. These activities provide direct support for services, either through direct support to implement needed services within a community through discretionary grants or, more broadly, through block and formula grants to States. SAMHSA's Targeted Capacity Expansion programs are discretionary programs specifically intended to target service gaps, community needs, or emerging problems. Special grant programs provide resources to meet these needs. Within these relatively new programs, services funded are based upon best practices models, and results are carefully evaluated. Block and formula grant programs permit States or other designated recipients to allocate resources to ensure basic access or to meet identified needs.

An example of a Targeted Capacity Expansion program is the State Incentive Grants program in CSAP, which provides incentives to States to improve collaboration among State agencies, community organizations, and other prevention groups to promote community use of scientifically defensible prevention services and policies and to optimize, redirect, and leverage use of all funding streams for prevention. First awards for this program were made in FY 1997. States have agreed on the use of core data to be collected across sites at the State, subrecipient, and program levels. It is anticipated that the results of this program will include measurable decreases in past month substance abuse among youth. States also will document and evaluate the new or modified prevention systems that result from these grants, and do qualitative comparisons with the old prevention system.

An example of a formula grant program (other than the two SAMHSA block grants) is the mental health Projects for Assistance in Transition from Homelessness (PATH) program. Through a formula grant to each State and territory, States can provide flexible, community based services for people with serious mental illness who are homeless or at imminent risk of becoming homeless. This program was established in 1990. Data collection has been ongoing for a number of years. Measures include persons contacted, the proportion of participating agencies that offer outreach services, and the percentage contacted who become clients of the mental health system.

#### **Goal 4. Enhance service system performance**

Relevant Budget Lines: National Data Collection (funds were not appropriated to this budget line in FY 1999); 5% set-aside from the MH and SAPT block grants.

Performance Indicators: Results of these activities are to be assessed utilizing feedback from users of the data, information, or other systems.

SAMHSA also enhances service system performance through activities that support the delivery of services, such as primary data collection and reporting; support of data infrastructure development at Federal, State, and local levels; conduct of broad program evaluations; and other similar infrastructure issues. This goal relates to infrastructure issues at all levels, from broad infrastructure development efforts within the Public Health Service to small area data and information collection and analysis that can assist States in determining how to allocate their block grant allotments in order to have the greatest impact on services needs. For FY 1999 and FY 2000, SAMHSA is focusing on data issues within this goal. Future plans will address agency activities related to other aspects of infrastructure support and development. These activities currently represent a very small proportion of SAMHSA's funding, and are carried out in support of the agency's other programs, but growth is essential in order to support the data needs of Healthy People 2010 and the National Drug Control Strategy, as well as SAMHSA's implementation of GPRA.

An example of SAMHSA's activities with respect to national data collection is the expansion of the National Household Survey on Drug Abuse (NHSDA). This expansion will provide State-level estimates of the prevalence of substance abuse in the 50 States and in the District of Columbia. As a result of the expansion, it will be possible to identify States with relatively high or low rates. A second example of an ongoing activity that addresses infrastructure issues is the CMHS Mental Health Statistics Improvement Program's Consumer Oriented Report Card, which was developed to provide feedback to consumers and family members on issues of access, appropriateness, prevention and outcome in managed care programs. Currently, it is being tested in 41 States. This report card is the only one in the field that is consumer focused, and the only one that includes outcome measures. It has been endorsed by key national mental health groups, such as the National Association of State Mental Health Program Directors, the National Alliance for the Mentally Ill, the American Association of Behavioral Healthcare, and the National Association of State Mental Health Planning Councils.

#### **Core Set of Client Outcome Measures**

SAMHSA and the Centers have developed a core set of client outcome measures for discretionary programs and projects which will begin to be applied to programs, following OMB approval, beginning in FY 1999. The goal is to implement data collection across all discretionary programs by FY 2000.

I. Summary Measure for Outcomes: Increase the proportion of the populations affected by SAMHSA programs that demonstrate improved outcomes based upon identified measures.

#### II. Substance Abuse Prevention Outcomes:

- A. Over the past month, for those receiving services, the percent of children compared to the national average or project baseline:
  1. Using substances declined

2. Strongly disapproving of substance use increased
  3. Perceiving personal/health risks associated with the consequences of substance abuse increased
  4. Having used substances showed an increase in age of first use
  5. Expecting ever to use substances declined
- B. Over the past month, the percent of parents/adults receiving services, compared to the national average or project baseline:
1. Using illegal drugs declined
  2. Strongly disapproving of substance abuse/misuse increased
  3. Perceiving personal/health risks associated with the consequences of substance abuse/misuse increased
  4. Having used substances showed an increase in age of first use
  5. Expecting ever to use substances declined
- III. Mental Health and Substance Abuse Treatment Outcomes:
- A. Over the past year, percent of adults receiving services increased who:
1. Were currently employed or engaged in productive activities
  2. Had a permanent place to live in the community
  3. Had no/reduced involvement with the criminal justice system
  4. Experienced no/ reduced alcohol or illegal drug related health, behavior, or social consequences
- B. Over the past year, percent of children/adolescents under age 18 receiving services increased who:
1. Were attending school
  2. Were residing in a stable living environment
  3. Had no/reduced involvement in the juvenile justice system
  4. Had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds)
- IV. Substance Abuse Prevention and Treatment Outcomes:
- A. Percent increase of adults receiving services who had no past month substance abuse
- B. Over the past month, percent increase of youth (population data limited to 12-17 year olds) receiving services who experienced no/reduced substance abuse related health, behavior, or social consequences

The development of client outcome measures for block and formula grants is occurring in partnership with States. It is expected that many if not most of the areas or domains included in the client outcome measures for discretionary programs will be included in a future core set of measures for the block grant. All of these domains are included in sets of indicators now being tested by States and soon to be reported on a voluntary basis as part of the block grant application.

## **Partners and Stakeholders**

Mental health and substance abuse issues bring together a broad array of partners and stakeholders whose input is critical to the determination of agency priorities.

Partners and stakeholders include State and local governments; providers; consumers/clients of substance abuse and mental health services; family members of individuals with substance abuse or mental illness; grantees; foundations; and a variety of volunteer and other organizations that do not fall within the categories mentioned. Involved Federal agencies include, but are not limited to, all of the HHS components but especially the Health Care Financing Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health; the Office of National Drug Control Policy; the Department of Education; the Department of Veterans Affairs; the Department of Justice; the Department of Transportation; the Department of Housing and Urban Development; and the Department of Defense.

States in particular are SAMHSA's partners in carrying out the two largest programs, the mental health and substance abuse block grants. There are several implications of this shared responsibility in terms of GPRA implementation. The majority of resources applied to mental health and substance abuse problems are not under SAMHSA's direct or indirect control. Therefore, accountability for outcomes for the block grants, or for the nation as a whole, is shared with States and others.

## **Data and Evaluation Issues**

SAMHSA has made considerable progress during the past year toward obtaining needed data and assuring that there is the necessary emphasis on evaluation of agency programs. However, several major issues remain, in particular the lack of resources to collect and analyze performance data for national policy goals as well as data for assessing the performance of certain of SAMHSA's programs.

### Status of Baselines, Targets, and Update Data

Discretionary programs generally can develop measures and begin to collect baseline data in the first year after award, and set targets and begin to collect update data in the second year. Most of SAMHSA's KD&A programs are limited to three years, with final reporting a year or more after the program is completed. Other than the expected lags between award, baseline data, target setting, and the collection and reporting of program data, SAMHSA does not anticipate difficulties in obtaining and reporting performance information for its discretionary programs.

SAMHSA also has baseline data, targets, and update data for its two mental health formula programs. While performance data are not yet available for the two block grants, SAMHSA has made considerable progress this year. The FY 2000 plan includes indicators for both the mental health and substance abuse Block Grants that have been under development, in conjunction with States, for several years. SAMHSA has now received approval for the first time from OMB to collect performance-related mental health information from States in the block grant application on a voluntary basis beginning in FY 1999. SAMHSA is continuing to work with the States, OMB, and others to reach agreement on a set of measures that will be the basis for a request for approval to collect performance-related substance abuse treatment information on a voluntary basis beginning in FY 2000; the proposed measures are included in this plan. The agency also has made considerable progress in working with the States to develop a set of substance abuse prevention measures.

### Data Strategy, Challenges, Costs, and Limitations

Allocating sufficient funds for data collection and analysis in any health area always requires difficult choices, and substance abuse and mental health are no exception. Despite the role of multiple agencies and entities in collecting important data, significant gaps in the availability of data remain.

Examples of SAMHSA national surveys include the National Household Survey on Drug Abuse (NHSDA), and the Inventory of Mental Health Organizations. Data from these surveys are used for GPRA purposes to set context and to establish and/or track the agency's broad, long-term goals that are also part of Healthy People 2010 and the ONDCP Performance Measures of Effectiveness effort. SAMHSA's top national data collection priority is the expansion of the NHSDA to permit State-level estimates. This expansion will assist SAMHSA in providing enhanced technical assistance to States which need additional assistance as reflected by higher prevalence of substance abuse.

The collection of national data in the area of mental health and mental illness has been substantially underfunded for many years. An illustration of this problem was the inability to track a number of mental health objectives within Healthy People 2000, because it never has been possible to obtain funding for the necessary data collection activities. Another illustration is the paucity of information on the incidence and prevalence of mental illnesses and mental disorders, especially in children. Although substance abuse data efforts have been funded somewhat more generously, the ONDCP PME effort again highlights that even for substance abuse, there are major gaps in essential data. An adequate investment in national data collection is essential to the effective tracking of national results.

#### C Support of State Data Efforts

Examples of SAMHSA support of State data collection efforts include needs assessment activities in CSAT and CSAP, and efforts to support States in developing performance measures and identifying and collecting related outcome and other data. In order to make full use of the Block Grants as a mechanism for improving, rather than just supporting, services and other activities in States, good information must exist on the activities and services needs of the State and on the outcomes of State efforts. Traditionally, data efforts have been among the first items cut when budgets are tight. The current lack of adequate data infrastructure in States to collect and report on performance and other necessary data reflects many years of limited funding. SAMHSA's top State data priority is support of activities to help States develop an adequate data infrastructure to permit the collection and reporting of essential data.

#### C Data Collection for GPRA Reporting

SAMHSA has the necessary authorities and funding to collect and report necessary data for all programs other than the Block Grants, utilizing a portion of program funds. However, for the block grants, SAMHSA lacks authority to require performance-related data. Despite this limitation, the States and SAMHSA have been working in voluntary partnership for several years to develop measures that are useful to States as well as to the Federal Government. SAMHSA has been able to use set-aside funds from each block grant to develop measures and pilot their application. The agency also should be able to obtain OMB approval to collect data on a voluntary basis for substance abuse treatment and prevention, as has been accomplished for mental health. SAMHSA has been advised by OMB that SAMHSA cannot require outcome data reporting as part of the block grant application, but must work with the States to urge them to report on a voluntary basis. OMB was, however, strongly supportive of such voluntary submission of data. A major impediment is that without infrastructure funding, there are many States that will not be able to take the essential next step of generating and reporting these data for mental health, substance abuse, or for both.

#### Evaluation

SAMHSA has implemented an evaluation policy that defines an integrated model of evaluation and planning. The formulation of programmatic and evaluation priorities includes consultation with the SAMHSA and Center Advisory Councils, and with other experts in the fields of evaluation and service delivery. Results from evaluations provide information useful for program planning and policy development, as the agency continues to refine its priorities and objectives. A common evaluation protocol is under development by the Centers that will ensure that the necessary evaluation information for SAMHSA's minimum set of program performance measures is available.

#### **Conclusion**

SAMHSA has made considerable progress in its GPRA implementation efforts this year, such as inclusion of long range goals and measures, performance indicators for both Block Grants, and the general strengthening of measures for SAMHSA's programs.

## Part II: Component Performance Plans

### Center for Mental Health Services

Note: The table which follows lists all significant Center for Mental Health Services (CMHS) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

	<u>First Funded</u>	<u>Completed</u>	<u>First Reported</u>
<u>Current Activities</u>			
Goal 3: Block/Formula Grants/TCE			
Childrens MH		Ongoing	
P&A		Ongoing	
PATH		Ongoing	
MHBG		Ongoing	
Goals 1 and 2: Knowledge Development and Knowledge Application			
ACCESS	FY 1993	FY 1999	FY 2000
Homelessness Prevention	FY 1996	FY 1999	FY 2000
Supported Housing	FY 1997	FY 2000	FY 2001
HIV/AIDS Education I		ongoing	FY 2000
HIV/AIDS Services Demo	FY 1994	FY 1998	FY 1999
AIDS High Risk	FY 1997	FY 2001	FY 2002
Employment (EIDP)	FY 1995	FY 2000	FY 2001
Managed Care	FY 1996	FY 1999	FY 2000
Community Action I	FY 1997	FY 1998	FY 1999
Criminal Justice	FY 1997	FY 2000	FY 2001
Starting Early/SS	FY 1997	FY 2001	FY 2002
KEN	FY 1995	ongoing	FY 1999
Consumer Services	FY 1998	FY 2002	FY 2003
Elderly Primary Care	FY 1998	FY 2002	FY 2002
Community Action II	FY 1998	FY 1999	FY 2000
Women and Violence	FY 1998	FY 2003	FY 2004
HIV/AIDS Outcome, Adherence	FY 1998	FY 2002	FY 2003
HIV/AIDS Education II	FY 1998	FY 2002	FY 2003
Native American Children	FY 1998	FY 2001	FY 2003
<u>New Activities</u>			
Consumer & Supporter TA Centers	FY 1999	FY 2001	
School-based Violence (Multiagency)	FY 1999	FY 2001	
School-based Violence (Action Grants)	FY 1999	FY 2001	
Alaska	FY 1999	FY 2000	

Community Action Phase I	FY 1999 ongoing
Homeless Families	FY 1999 FY 2004
Family & Consumer Network	FY 2000 ongoing
HIV/AIDS Continuum of Care	FY 2000 FY 2003

### **Goal 3: Assure services availability/Meet targeted needs**

#### **a. Community Mental Health Services Block Grant**

Goal: To improve community based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children and youth with serious emotional disturbances.

Measures: Standard SAMHSA outcome measures will be applied to this program. Pilot baseline data for outcomes will be available in FY 1999. Targets will be set at that time. The Block Grant Program has made considerable progress in developing program performance indicators, in collaboration with the States. A set of access, quality, and outcome measures has been approved by OMB for implementation on a voluntary basis in FY 1999, as part of the block grant application. In addition, ten States will be engaged in a 3 year pilot to test the feasibility of a national set of 28 performance indicators. These indicators are heavily weighted toward outcome assessment. Baselines will become available for these output and outcome measures in the fall of 1999.

The full array of indicators is as follows:

#### **Criterion 1: Comprehensive Community Based Mental Health System.**

##### ACCESS INDICATORS

- C Percentage of SMI persons (or SED persons or their parents) receiving services who rate access to care positively;
- C Number of persons with SMI (or SED) who are receiving case management services;
- C Number of persons with SMI (or SED) who are receiving housing services;
- C Number of persons with SMI who are receiving employment services;
- C Number of admissions to state and county hospitals among persons with SMI (or SED);
- C Number of patients-in-residence in state and county hospitals among persons with SMI (or SED);

##### APPROPRIATENESS/QUALITY INDICATORS

- C Percentage of SMI population (or SED persons or their parents) receiving services who rate the quality and appropriateness of care positively;
- C Increase percentage of SMI population (or SED persons or their parents) receiving services who positively rate respect and caring by their providers;
- C Increase percentage of SMI population who are actively involved in decisions regarding their own treatment;
- C Percentage of parents of children and adolescents who are in the SED population who are actively involved in decisions regarding their child's treatment;
- C Percentage of persons discharged from psychiatric inpatient care who receive a follow-up, face-to-face visit within seven days of discharge;
- C Percentage of persons discharged from psychiatric emergency care who receive a follow-up, face-to-face visit within seven days of discharge;
- C Percentage of SMI population who are receiving "supported housing" services;
- C Percentage of SMI population who are receiving "supported employment" services;
- C Percentage of SMI population who are receiving "assertive community team" services;
- C Percentage of SMI population who receive a physical health examination annually;

##### OUTCOME INDICATORS

- C Percentage of SMI population (or SED persons or their parents) receiving services who report positive outcomes of care (or for whom positive changes are reported);
- C Percentage of SMI population for whom there are positive changes in employment;
- C Percentage of SED population for whom there is improvement in school functioning;
- C Percentage of SMI population for whom there are positive changes in living situation;
- C Percentage of SMI population for whom there are improvements in personhood, hope, and recovery;
- C Percentage of SMI/SED population for whom there are positive changes in level of functioning;
- C Percentage of SMI/SED population for whom there is reduced distress from the symptoms of mental illness;
- C Percentage of SMI/SED population for whom there is either no impairment or reduced impairment from substance abuse;
- C Percentage of persons served with SMI who experience adverse outcomes of mental health services;
- C Percentage of persons readmitted to psychiatric inpatient care within 30 days of discharge.
- C Percentage of SMI population who spend one or more days in a jail or prison.

**Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data.**

POPULATION ACCESS INDICATORS

- C Percentage of adults with serious mental illness who receive publicly funded services;
- C Percentage of children with serious emotional disturbance who receive publicly funded services.

SPECIAL POPULATION INDICATORS

For all illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for significant sub-populations, including breakouts by

- Gender
- Ethnicity
- Race
- Sub-state geographic areas
- For Adults, age sub-groupings
- For Children & Adolescents, age sub-grouping

**Criterion 3: Targeted Services to Homeless and Rural Populations.**

- C Percentage of homeless persons with SMI (or SED) and who receive mental health services.
- C Percentage of rural persons with SMI (or SED) and who receive mental health services.
- C For all, relevant, illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for persons with SMI/SED and homeless and for persons who are SMI/SED and living in rural areas of the state.

**Criterion 4: Management Systems .**

- C Proportion of state mental health block grant funds allocated to innovative programs;
- C Percentage of SMHA-controlled expenditures for community programs of total SMHA-controlled expenditures;
- C Mental health expenditures *per capita*;
- C Mental health expenditures *per person served*;
- C Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring at the statewide level, the local mental health authority level, and the provider level.

FOR MENTAL HEALTH, MEDICAID MANAGED CARE PLANS:

- C Number of persons with SMI (or SED) and who are enrolled in Medicaid managed care for health and mental

- health services (integrated plan) or mental health/behavioral health services only (carve out plan);
- C *Per member per month* plan premium rate (statewide average);
- C Percent of total plan expenditures attributable to (1) Medical loss, (2) Administrative loss, and (3) Net Profit/loss.
- C Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring within the managed care plan.

**Criterion 5: Integration of Children's Services.**

- C Percentage of children with SED who are placed out-of-home (*e.g.*, foster care, residential home, juvenile detention).
- C Percentage of children with SED who are attending school regularly;
- C Percentage of children with SED who are also receiving special education services;
- C Percentage of children with SED who are also clients of the juvenile justice system;
- C Percentage of children who are SED who are also receiving substance abuse services.

**Measure 1: Three overarching SAMHSA outcome indicators for children with serious emotional disturbance and three overarching SAMHSA outcome indicators for adults with serious mental illnesses will be reported as part of the FY 1999 block grant applications, as follows: Increase the percent of adults with serious mental illness who are employed, are living independently, and have had no contact with the criminal justice system; and the percent of children with serious emotional disturbance who attend school regularly, reside in a stable environment, and have no contact with the juvenile justice system.**

FY 1999 Target: Baseline data will be available early in FY 2000.

FY 2000 Target: To be developed once baseline data are available.

Update Date: To be available in FY 2001.

Data Source/Validity of Data: On a voluntary basis information will be solicited in a nondirective format in the OMB approved Block Grant Application, 1999-2000. Initial experience in FY 1999 will identify need for improvements to data infrastructure. Data will be reported by States indicating sources within states.

**Measure 2: Ten States will pilot 28 performance indicators between FY 1998 - FY 2001.**

Rationale: In the FY 1998 pilot, ten states began piloting 28 performance measures State wide. By FY 2001, this pilot work will be completed. This set of 28 performance measures has been identified through the 5 State Feasibility Study funded in FY 1997. Results support the feasibility of piloting a common set of performance indicators for the States. The 28 OMB-approved performance measures constitute a sample menu for inclusion in the FY 1999 Block Grant Application. OMB has designated the overall format as voluntary and measures are provided as a sample menu for selection, not as a blueprint or a requirement; states may also develop and use additional indicators which are unique. The conceptual foundation for the 28 indicators is the MHSIP Consumer Oriented Report Card for managed behavioral healthcare, which is now being tested in 41 States.

FY 1999 Target: Baseline data will be available early in FY 2000

FY 2000 Target: To be developed once baseline data are available.

Update Date: To be available in FY 2001.

Data Source/Validity of Data: State Mental Health systems will collect this data each year. Data accuracy will be assessed in the Pilot. States included in the first phase (5 State Feasibility Study) will continue to collect this data. The Five State Study documented the feasibility of piloting these 28 indicators in a comparable way across States.

**b. CMHS Comprehensive Community Mental Health Services for Children and Their Families**

Goal: To successfully implement systems of care for children with serious emotional disturbance and their families in grantee sites; and to improve outcomes for children and their families served in these systems of care. Empirical

evidence suggests that system-of-care programs increase the access that children with serious emotional disturbance and their families have to a wide array of services as compared to programs delivering services as usual. There is also preliminary evidence from the multisite evaluation of the CMHS comprehensive program that outcomes for children and their families improve in CMHS projects that apply the system-of-care approach.

Measures: Standard measures will be applied to this program, but existing measures as modified below will continue to be utilized as well. Note that some process measures included in the FY 1999 plan have been deleted or reclassified. Former measure 3, Increase Referrals from Juvenile Justice, has replaced former Joint Contribution of Mental Health Service Components of Other Non-Mental Health Child-serving Agencies as an indicator of Measure 1, referred to as Increased Interagency Collaboration. Also note that Measure 6, Increase Stability of Living Arrangements is now listed as Measure 5. An indicator for Measure 3, Improved Child Outcomes, has been added, namely, Increase the Children with Law Enforcement Contacts at Entry Who Have no Law Enforcement Contacts After Six Months. These changes were mostly made to reflect guidance to reduce the number of measures in the GPRA plan. Inasmuch as FY 1998 data are not yet available and the FY 1999 targets were very aggressive with respect to improved results, CMHS has retained the FY 1999 targets for FY 2000.

Progress report: The increase in the budget for this program has permitted funding more sites. Evaluation, technical assistance, and communication activities are an integral part of this program. Success to date is documented in the following preliminary results. Based on data collected through August 1997, preliminary findings show notable improvements for children who are in services for at least six months. For example, using standard measures, evaluation indicates that after six months:

- C levels of functional impairment decreased by 20%,
- C average or above average grades increased by 13%,
- C infrequent school attendance reduced by 42%,
- C decrease in law enforcement contacts for 47% of children with law enforcement contacts at intake,
- C decrease to none living arrangement among 49% of children with multiple arrangements at intake.

**Measure 1: Increase Interagency Collaboration as reflected below**

Rationale: Collaboration across human service agencies is a critical component of the system of care approach. It helps to insure that the whole child will be served, funding resources for the treatment needs of the child will be maximized, and the opportunity for the child to have the optimum set of services available will increase. The set of indicators below examines the degree to which process features of the system-of-care approach result in increased interagency collaboration.

Measure	FY 1997 Baseline	FY 1998 Target	FY 1999 Target	FY 2000 Target
Increased Interagency Collaboration	75%	Referrals from other non-MH agencies for MH services will increase by 5%	Such referrals will increase by 10%	Such referrals will increase by 10%
	9%	Referrals from juvenile justice programs will increase by 10%	Such referrals will increase by 12%	Such referrals will increase by 12%
	40%	Case records that reflect cross-agency treatment planning will	Such case records will increase by 10%	Such case records will increase by 10%

		increase by 5%		
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Data Sources/Validity of Data: Data are derived from sources such as document reviews, structured and semi-structured interviews, and observations. Some of these data are collected prior to and during annual sites visits, and some are collected from a multisite longitudinal outcome study.

Progress report: Data are being analyzed.

**Measure 2: Decrease Utilization of Inpatient/Residential Treatment by 20% of FY 1997 base, as measured by average days in facility.**

Rationale: Children with serious emotional disturbance have historically been observed in inpatient/residential treatment programs because of a lack of community-based systems of care. Reducing reliance on residential facilities while at the same time creating service options within the community will demonstrate the development of community-based systems of care.

FY 1997 Baseline: 265 days

FY 1998 Target: Decrease of 10% of FY 1997 base in inpatient/residential days.

FY 1999 Target: Decrease of 20% of FY 1997 base in inpatient/residential days.

FY 2000 Target: Decrease of 20% of FY 1997 base in inpatient/residential days.

Data Sources: Data are derived from site-specific document reviews. These data are collected prior to and during annual site visits.

Progress report: Data are being analyzed.

**Measure 3: Improve Child Outcomes as reflected below**

Rationale: Studies have shown that school attendance correlates positively with overall school performance. There are also strong expectations that law enforcement contacts are reduced among children served through systems of care.

Measure	FY 1997 Baseline	FY 1998 Target	FY 1999 Target	FY 2000 Target
Improved Child Outcomes	70% of time in school	Increase by 5% the number of children attending school 75% of the time.	Increase by 10% the number of children attending school 75% of the time.	Increase by 10% the number of children attending school 75% of the time.
	47% of children with law enforcement contacts at entry have no such contacts after	Increase to 52% the children with law enforcement contacts at entry who have no such	Increase to 57% the children with law enforcement contacts at entry who have no such	Increase to 57% the children with law enforcement contacts at entry who have no such

	six months	contacts after six months	contacts after six months	contacts after six months
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Data Sources/Validity of Data: Data are derived from document reviews. These data are collected prior to and during annual site visits. Some of the data are also collected from a multisite core longitudinal study.

Progress report: Data are being analyzed.

**Measure 4: Increase Level of Family Satisfaction with Services by 10% over FY 1997**

Rationale: Family involvement is a cornerstone of systems of care. Increasing the satisfaction rate of families receiving services shows that the level and type of care are those the customer desires.

FY 1997 Baseline: 70%

FY 1998 Target: Increase of 5% over FY 1997 baseline.

FY 1999 Target: Increase of 10% over 1997 baseline.

FY 2000 Target: Increase of 10% over 1997 baseline.

Data Source/Validity of Data: Data from two instruments measuring satisfaction outcomes will be collected: Family/Caregiver Satisfaction and Youth Satisfaction. These instruments were adapted from the work of Professor John Burchard at the University of Vermont. Items have been added to specifically address issues of cultural competence, and family-centered attributes which are hallmark characteristics of the system of care. The strength of this dual approach (youth and caregiver) is that it provides numeric values to the experiences of children and families so that it will be possible to compare quantitative data yielded from the satisfaction scales with qualitative data gathered through interviews and case studies conducted with children and families.

Progress report: Data are being analyzed.

**Measure 5: Increase stability of living arrangements by decreasing the number of children having more than one living arrangement after 6 months in services by 25%**

Rationale: Stability of the living arrangement is a key outcome of quality and comprehensiveness of services. It is a crucial condition for child development and for an acceptable family environment.

FY 1997 Baseline: 76% had more than one living arrangement after 6 months in services.

FY 1998 Target: Reduce by 10% over FY 1997 baseline.

FY 1999 Target: Reduce by 20% over 1997 baseline.

FY 2000 Target: Reduce by 25% over 1997 baseline.

Data Source/Validity of Data: Data are derived from an instrument entitled Residential Living Environments and Placement Stability Scale, developed by the Pressley Ridge School, Pittsburgh, PA, in order to operationalize the construct of restrictiveness. Restrictiveness was defined as limits placed on freedom of movement or choice by a physical facility, by rules and regulations, and by conditions of entry or departure. This scale incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins and colleagues (1992) with a Placement Stability Scale. Stability of placements is assessed by the number of days spent in each residential setting and the number of total placement changes over a specified data collection period.

Progress Report: Data are being analyzed.

**c. CMHS Protection and Advocacy for Individuals with Mental Illness (PAIMI) - Services Formula Grants**

Goal: Through advocacy activities, the PAIMI Program will reduce the incidents of abuse, neglect, and civil rights violations of individuals with mental illness who are placed in residential treatment and care facilities.

Measures: Some measures currently used were set out in the FY 1999 GPRA Performance Plan. The the number of clients served has been narrowed to focus on the number of abuse complaints. The measures were developed through an interagency effort (Administration on Developmental Disabilities (DHHS/ADD), the Department of Education, Rehabilitation Services Administration (RSA), and the Center for Mental Health Services (CMHS)) and are applicable to related protection and advocacy program activities administrated by other federal agencies. These measures will also be used in subsequent years. Interagency collaboration on the refinement, testing, and implementation of these performance measures will continue through FY 1998 and into FY 1999. The data sources for all measures are the annual Program Performance Review (PPR) and Advisory Council (AC) Reports submitted by each of the 56 P&A systems in December. The information provided in these reports is generally reliable.

**Measure 1: At least 9,000 complaints of abuse will be addressed by State PAIMI systems.**

Rationale: Of the 23,957 complaints concerning abuse, neglect and rights violations PAIMI programs addressed in FY 1998, the number of abuse cases has increased 36 percent. The majority of these abuse cases include failure to provide mental health treatment, physical assault, inappropriate or excessive restraint/seclusion, failure to provide medical treatment and inappropriate or excessive medication. In addition, there were numerous incidents involving mental health patients who died while under treatment in State hospital facilities. State P&A investigations into these highly publicized deaths found that the treatment facility staff used either excessive physical restraint or provided inadequate medical care.

FY 1997 Baseline: 8360 abuse complaints were addressed  
FY 1998 Baseline: 8500 abuse complaints were addressed  
FY 1999 Target: 9000 abuse complaints will be addressed  
FY 2000 Target: 9000 abuse complaints will be addressed

**Measure 2: Maintain at 160,000 the number of individuals attending public education and/or constituency training activities and public awareness activities offered by the PAIMI programs.**

Rationale: Expansion of outreach services, the provision of advocacy training to consumers and distribution of information generally on such topics as disability rights, consumer self-advocacy, the PAIMI Act, and State P&A systems will increase the general public awareness and general understanding of the availability of PAIMI services.

FY 1997 Baseline: 150, 916 individuals attended public education and/or constituency training and public awareness activities.  
FY 1998 Target: Increase to 155,000 the number of individuals (Target revised upward).  
FY 1999 Target: Increase to 160,000 the number of individuals (Target revised upward).  
FY 2000 Target: Maintain at 160,000 the number of individuals (Target revised upward).

**Measure 3: Maintain at 70% the percentage of priorities and goals assessed by the PAIMI Advisory Council to have made substantial progress or to have been achieved.**

Rationale: This measure assesses the performance of the PAIMI programs in accomplishing their goals and objectives.

FY 1997 Baseline: Approximately 70 percent of priorities and goals had substantial progress or were achieved.  
FY 1998 Target: Maintain 70% progress on priorities and goals.  
FY 1999 Target: Maintain 70% progress on priorities and goals.  
FY 2000 Target: Maintain 70% progress on priorities and goals.  
FY 2001 Target: Maintain 70% progress on priorities and goals.

**Measure 4: Increase of substantiated incidents of abuse, neglect, or rights violations reported by clients which are favorably resolved.**

Rationale: This measure assesses the performance outcome of a PAIMI programs activities in favorably resolving

complaints from individuals.

FY 1999 Baseline: To be determined after baseline data are collected. Anticipated at end of second quarter in FY 1999.

FY 1999 Target: To be developed.

FY 2000 Target: To be developed.

FY 2001 Target: To be developed.

**d. CMHS Projects for Assistance in Transition from Homelessness (PATH) - Services Formula Grants**

Goal: To provide services that will enable persons who are homeless and have serious mental illnesses to be placed in appropriate housing situations and engage them with formal mental health treatment and systems so as to improve their mental health functioning.

Measures: This program will transition to new measures; existing measures may also be used.

Program Update/Performance Report: PATH programs have been successful in targeting assistance to persons who have the most serious impairments. Among all clients who reported PATH-funded services in 1996, nearly 36% had schizophrenia and other psychotic disorders. Another 37% had affective disorders, including severe depression and bipolar disorder. At least 66 % had co-occurring serious mental illnesses and alcohol and substance use disorders. At the time of first contact with providers, half of all clients living in the streets, in shelters or in temporary housing had been homeless for more than 30 days. Despite the fact that they have multiple and complex needs and may be difficult to reach, 36% of the homeless individuals contacted through PATH-funded outreach were eventually engaged in some type of services.

**Measure 1: Increase to 115,000 the number of persons contacted relative to the population in need**

FY 1996 (Baseline)	FY 1997 (Projected Baseline)	FY 1998 (Projected Baseline)	FY 1999 Target	FY 2000 Target
118,000/600,000	80,000/600,000	92,000/600,000	102,000/600,000	115,000/600,000

Discussion: A person contacted is someone, not necessarily a PATH client, who meets with a PATH funded staff person providing outreach services. Some persons contacted are not willing to accept other services during the reporting period; others are not eligible, usually because they do not have a serious mental illness. The number of persons a PATH funded provider contacts relative to need is a measure of impact. Thus, in FY 1996, the PATH program contacted about 20 percent (118,000) of the estimated eligible population.

The PATH program experienced a 32 percent decrease of funding from \$29.6 million in FY 1995 to \$20 million in FY 1996. Because most States programs have elected to use their annual PATH funds on an award start date that occurs late in the fiscal year, a possible decrease in the number of persons contacted will not be statistically evident until FY 1997 data are compiled. The FY 2000 budget increase would enable PATH funded programs to contact additional persons. This increase is reflected in the target for the FY 2000 GPRA performance plan, but the funding increase actually reaches programs late in FY 2000. Therefore, the effects of the budget increase are most evident in FY 2001 data, which are not reported until FY 2002.

Data Source/Validity of Data: The source of the data on the population in need is derived from national estimates of the number of persons who are homeless, applying to that number, based on studies in specific locations, an estimated percentage of homeless persons who have serious mental illnesses. The quality of the data on the number of persons contacted varies. To improve the quality, the PATH program will, after consultation with State PATH contacts, formulate and distribute a definition of a person contacted. Other quality control measures also are expected to improve data collection and reporting, and may result in subsequent revision of GPRA targets.

**Measure 2: At least 80% of participating agencies offer outreach services**

Discussion: Outreach is the most frequently provided PATH-funded service. The Center for Mental Health Services will encourage States to increase their funding for outreach services. As the federal PATH appropriation has decreased, the strategy of using PATH funds to connect the eligible population with existing, rather than additional community resources, is even more important. The challenge for local providers will be to maintain outreach services at close to current levels rather than offer later stage services whose availability may have decreased as a result of reduced resources in affiliated non-PATH programs. A \$31 million appropriation will enable the percentage of participating agencies offering outreach services to increase from at least 70 percent to at least 80 percent.

FY 1996 Baseline: 82%

FY 1997: Data collected; to be released in mid-1999.

FY 1998 Target: 70%

FY 1999 Target: 70%

FY 2000 Target: 80%

Data Source/Validity of Data: The source of the information is data that States submit annually to CMHS. Since the sources of the State data are the local agencies that provide the services, the quality of the data is very good.

**Measure 3: Maintain the percentage of persons contacted who become enrolled clients at 30% or greater**

Discussion: Most local PATH funded agencies provide outreach services. In fact, PATH funds are often the only monies available to communities to support outreach to, and engagement of, clients and their transition to mainstream services. The process of outreach requires skill in gaining the trust of persons who, in many cases, are reluctant to accept help. In FY 1996, PATH providers successfully enrolled 36 percent of persons contacted as clients. In most cases, they provided for, or arranged to meet immediate needs of clients, often found temporary or longer term shelter and arranged for mental health treatment.

However, not all persons contacted, even those willing to accept help, were eligible for PATH-funded services. In many cases, as mentioned above, it may have turned out that the person contacted, after further assessment, did not have a serious mental illness. In these cases, the person was assisted by the PATH-funded agency, but through services funded by non-PATH sources, or was referred to another agency.

As PATH appropriations have decreased and funds for related resources that outreach workers can offer are decreased, the incentive for homeless persons with serious mental illnesses to accept outreach services will decrease. Outreach workers will need to make increasing use of existing resources to engage and further assist potential clients. A \$31 million appropriation in FY 2000 will enable PATH funded programs to enroll at least 33 percent, rather than the previous minimum of 30 percent, of persons contacted. While this expected increase is reflected in the target for the FY 2000 GPRA performance plan, the funding increase will actually reach programs late in FY 2000. Therefore, the effects of the budget increase are most evident in FY 2001 data, which are not reported until FY 2002.

FY 1996 Baseline: 36%

FY 1997 Baseline: Data collected; to be released in mid-1999.

FY 1998 Target: 30%

FY 1999 Target: 30%

FY 2000 Target: 33%

Data source/Validity of Data: The sources of the data are States which receive these data from local providers. The data on **persons contacted**, as mentioned above, are of varying quality. Data on **clients** are of good quality. A working definition of **client** is provided to States and local PATH funded agencies and is customarily followed.

**Goal 1: Bridge the gap between knowledge and practice**

**a. Access to Community Care and Effective Services and Supports (ACCESS); Cooperative Agreement**

## Demonstration Program

Goal: This program is examining the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill and on improving outcomes for this population.

Measures: This program is nearing completion. Two of the three measures from the FY 1999 GPRA Performance Plan will not be reported in FY 2000. Measure 1, which was a process measure involving the percent of integration strategies implemented, has been dropped in response to guidance indicating that the overall number of measures, particularly process measures, should be reduced. The new Measure 1 on level of systems integration was added to improve performance monitoring. It is maintained in the Plan but data will only be reported for FY 1999 and FY 2001 because it is collected biennially.

Program Update/Performance Report: An evaluation is being conducted that has both a systems-level and client-level focus. The system level evaluation will document the implementation process of the systems integration approaches, identify implementation barriers and facilitators, and measure system outcomes. The client level evaluation will determine whether systems integration efforts result in improved service delivery, improvements in mental health, substance abuse and health status, rehabilitation, quality of life and permanent exit from homelessness. A sixth year of data collection has been added to examine whether systems integration efforts are sustained and client outcomes continue to improve beyond Federal funding. Results will be ready for full reporting in FY 2001.

**Measure 1: Maintain level of systems integration at .74 in FY 2000. The data for this measure are collected biennially; collections are for reporting in FY 1999 and FY 2001.**

Rationale: ACCESS predicts that the level of systems integration at each of the project sites will increase over 4 points of time during the life of the program. The level of systems integration is being tested as a predictor of services outcomes.

FY 1994 Baseline:	Experimental Sites = .43	Comparison Sites = .45
FY 1996 1st mid-point:	Experimental Sites = .57	Comparison Sites = .58
FY 1998 2nd mid-point:	Experimental Sites = .66	Comparison Sites = .57
FY 1999 target:	Experimental Sites = .74	Comparison Sites = .57
FY 2000 target:	Experimental Sites = .74	Comparison Sites = .57

Discussion: Systems integration is defined as the proportion of agencies that have multiple service links with the ACCESS grantee. Service links are defined as client referrals, exchange of funds, information flow and coordination. This measure ranges from 0 to 1 with 1 indicating the highest level of systems integration. The measures of systems integration that were collected at baseline (FY 1994) and at the two mid-points (FY 1996 and FY 1998) indicate that over time, the experimental sites were able to develop more integrated service systems than the comparison sites. It is expected that the level of systems integration will continue to increase in the experimental sites and remain constant or decrease in the comparison sites. The final measure of systems integration, which will be collected during FY 2000, is expected to be approximately .74 for the experimental sites and .57 for the comparison sites.

Data Source/Validity of Data: The data collection and analysis are included in the inter-organizational study to be done by the contractor. High validity is expected due to the experience of the contractor and the established methodology.

**Measure 2: Improvements in client outcomes at twelve months for cohort 4 will be equal to or greater than the improvement at twelve months for cohorts 1, 2, and 3.**

Rationale: Enhancing clinical services in both the integration and comparison groups should result in improvements in client outcomes. Future analyses will compare changes in access to services and supports between the integration and comparison sites to determine the extent to which an integrated services system has an impact on persons who are homeless with serious mental illness.

First Cohort (data available in FY 1996): 12 month follow up data on the first cohort of ACCESS subjects shows: (1) number of days housed increased by 600%; (2) total number of days of drug use decreased by 45.6%; (3) number of days in outpatient psychiatric services increased by 19.76%; and (4) percentage committing a minor crime decreased by 45.5%.

Second Cohort (data available in FY 1997): 12 month follow up data on the second cohort of ACCESS subjects shows: (1) number of days housed increased by 528.6%; (2) total number of days of drug use decreased by 37.6%; (3) number of days in outpatient psychiatric services increased by 49.5%; and (4) percentage committing a minor crime decreased by 50%.

Third Cohort (data available in FY 1998): 12 month follow up data on the third cohort of ACCESS subjects shows: (1) number of days housed increased by 613.8%; (2) total number of days of drug use decreased by 14.3%; (3) number of days in outpatient psychiatric services increased by 30.0%; and (4) percentage committing a minor crime decreased by 41.7%.

Fourth Cohorts (data available in FY 1999): Equal to or exceed the above outcomes.

Data Source/Validity of Data: The subcontractor will collect repeated measures with standardized instruments. High validity and reliability are expected.

**b. CMHS Employment Intervention Demonstration Program (EIDP)**

Goal: The goal of this program is the development of knowledge of the most effective approaches for enhancing competitive employment for adults with severe mental illness.

Program Update/Performance Report: Enrollment is now completed at each site and two year follow up data will be collected for all participants by the end of this program. Because employment is episodic, results regarding long term outcomes are necessary. Preliminary data indicate that persons with serious mental illness are employable - over half of those receiving services for 9 or more months have held at least one job and work productivity remains high. To date, integrated approaches show higher rates of locating jobs than do nonintegrated approaches.

**Measure 1: Employment outcomes will significantly improve at intervention projects.**

Rationale: Standard research evaluation procedures (i.e., hierarchical linear models (HLM) for multi site data analyses) will be followed and reviewed by experts within and outside the EIDP. The project will evaluate numbers of days employed, pay, tenure, and characteristics of jobs.

FY 1998 Baseline: Preliminary analyses of first two years of program data completed by late FY 1999.

FY 1999 Target: Preliminary multi variate (HLM) analyses conducted on work outcomes in first three waves of data (baseline, 6 months, 12 months)

FT 2000 Target: Multi variate (HLM) analyses conducted on work outcomes across 5 time points (baseline, 6 months, 12 months, 18 months, 24 months)

Data Source/Validity of Data: Reliability of data is assessed through standard research procedures. Data are collected within the program and analyses are performed by the coordinating center.

**Measure 2: Development of direct costs for various models of interventions and models of usual services.**

Rationale: Program costs are needed in optimal program planning. A descriptive analysis of individual site program costs can provide useful information to those considering model implementation.

FY 1998 Baseline: Site by site audit of each program's ability to provide and document cost data completed by end of FY 1998.

FY 1999 Target: Detailed descriptions of each site's documented program costs prepared by late FY 1999.

FY 2000 Target: Analysis of data on each site's program costs prepared by late FY 2000.

Data Source/Validity of Data: Detailed service utilization data are collected within the programs and the coordinating center will collect and analyze cost data from each site.

## **Goal 2: Promote the adoption of best practices**

### **a. CMHS National Mental Health Services Knowledge Exchange Network (Knowledge Application)**

Goal: To provide information about mental health via various media to users of mental health services, their families, the general public, policy makers, providers, and researchers. The dissemination of timely, organized, and easily accessed information is crucial to the informed use of services and policy decisions.

Measures: The first measure from the FY 1999 GPRA Performance Plan, as modified below, will be used during the development of a second measure. Targets for the new measure will be reassessed as data are reviewed.

Program Update/Performance Report: Activity is greatly increased. Advancement in technology has made the bulletin board service (bbs) not a useful approach to dissemination and plans tentatively are for its phase out in FY 1999.

#### **Measure 1: Increase the usefulness of KEN information.**

Rationale: Usefulness will be assessed by a review of comments received in response to a KEN user satisfaction survey.

FY 1999 Baseline: User assessment of the usefulness of KEN information in FY 1999.

**Measure 2: Increase by 10% each year the number of requests for brochures, information kits, and publications; the number of written and telephone inquiries; and the number of connects to the World Wide Web site.**

Rationale: These data provide a concrete measure of successful performance. The increase in use of KEN indicates the need for and usefulness of this information and the format.

	INQUIRIES	WEB HITS	BBS
FY 1996	10,324	11,108*	39,026
FY 1997	26,603	152,355	91,033
FY 1998	32,058	105,175	216,012

\* Web service from April to September 1996

FY 1998 Baseline: For FY 1998, there were 54,000 hits, approximately 12,000 inquiries, and 61,000 bbs connections.

FY 1999 Target: Maintain or exceed the FY 1998 hits and inquiries

FY 2000 Target: Exceed the FY 1998 hits and inquiries

Data Source/Validity of Data: Monthly reports from KEN contractor are anticipated to have high validity.

#### **b. Community Action Grants (CAG) for Service Systems Change**

Goal: To identify exemplary practices for mental health services to persons with serious mental illness and to accomplish adoption of such practices in as many communities as possible.

Measures: FY 1999 data are not yet available to develop the FY 2000 targets. Baseline data will be available in FY 2000. This information is necessary before the target percentages can be adjusted in future years.

Program Update/Performance Report: In FY 1997, twenty Phase I Community Action Grants were awarded. In FY 1998, the Basic Phase I Action Grant Program continues to target children with serious emotional disturbances and adults with serious mental illness who may also have co-occurring disorders. In addition to this Basic Program, a joint effort among SAMHSA's Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and CMHS targets Hispanic communities to support the adoption of exemplary practices for Hispanic adults and adolescents with mental health and/or substance abuse problems. Data for grants funded in September 1997 will be available in March 1999.

Examples of activities to date include:

1. CAGs in rural South Carolina and the City of Berkeley (California) are working to reach agreement on adopting the Program for Assertive Community Treatment (PACT) - a proven and effective clinical team approach for the seriously mentally ill person. In 1997, CMHS funded the development of the standards for PACT and shortly thereafter the State of Texas mandated PACT to become standard practice and cover every foot in the great State.
2. Pennsylvania, California, Maine, Washington, D.C., and New York are developing consensus to implement effective wrap-around and coordinated services for children and adolescents coping with serious emotional disorders.
3. Maine has completed the consensus process and has begun to implement the exemplary practice of family psychoeducation.

**Measure 1: 50% of Phase I grantees achieve consensus on, and move toward adoption of an exemplary practice within their community's system of care. 50% of grantees have appropriate process data to enable them to move to Phase II.**

Rationale: Phase I grants are for a maximum of one year. The goal of these grants is to reach consensus or agreement among all key stakeholders that the exemplary practice can and should be implemented. Consensus must be in sufficient detail that it resolves all critical issues and represents a commitment to adopt the practice within a certain timetable. Since this is a new program, targets will be revised when the first round of grants is completed and baseline percentages are established.

FY 1998 Projected Baseline: 40% reach consensus and move toward adoption.  
FY 2000 Target: Increase to 50%

Data Source/Validity of Data: Program records of grant reports will include consensus information and actions taken.

**Measure 2: 50% of exemplary practices funded in Phase I grants are adopted in Phase II.**

Rationale: The first Phase II grants are planned to be awarded in FY 1999. Successful grantees will have up to two years to fully adopt an exemplary practice that has been agreed upon by the stakeholders. Since these grants will not be awarded until FY 1999, all targets will be revised when the first round of grants is completed and the baseline percentages are established.

FY 1999 Baseline: To be determined.  
FY 2000 Target: To be determined

Data Source/Validity: Program records will include consensus information and actions taken.

**Goal 4: Enhancing service system performance**

No programs highlighted prior to FY 2000.

## Center for Substance Abuse Prevention

Note: The table which follows lists all significant Center for Substance Abuse Prevention (CSAP) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

<b>Programs</b>	<b>First Funded</b>	<b>Completed</b>	<b>First Reported</b>
Current			
Goal 1: Prevention Intervention Studies on Predictor Variable by Developmental Stages	FY 1996	ongoing	FY 1999
Goal 1: Starting Early/ Starting Smart: Early Childhood Collaboration Project	FY 1997	ongoing	FY 2000
Goal 1: Workplace Managed Care	FY 1997	ongoing	FY 2000
Goal 1: Youth Connect-High Risk Youth Mentoring/ Advocacy Program	FY 1998	ongoing	FY 2001
Goal 1: Initiatives on Welfare Reform and Substance Abuse Prevention for Parenting ( Short title: Parenting Adolescents)	FY 1998	ongoing	FY 2001
Goal 1: Children of Substance Abusing Parents (COSAP)	FY 1998	ongoing	FY 2001
Goal 2: CSAP Clearinghouse program	FY 1997	ongoing	FY 2000
Goal 2: Centers for the Application of Prevention Technologies (CAPT)	FY 1997	ongoing	FY 2000
Goal 2: National Public Education Efforts (linked to YSAPI)	FY 1997	ongoing	FY 2000
Goal 3: CSAP Community Coalitions Program	FY 1997	FY 1999	FY 1999
Goal 3: State Incentive Grants (component of YSAPI)	FY 1997	ongoing	FY 2000
Goal 3: CSAP 20% Percent SAPT Block Grant Prevention Set-Aside	FY 1997	ongoing	FY 2000
Expected			
Goal 1: Vulnerable Populations	FY 1999	FY 2002	FY 2003
Goal 1: Family Strengthening	FY 1999	FY 2002	FY 2003

### **Goal 3: Assure services availability/meet targeted needs**

#### **a. CSAP 20% SAPT Block Grant Prevention Set-Aside**

Goal: To assist States and communities to expand and enhance the availability, delivery, and quality of substance abuse prevention services nationally, while enhancing State flexibility to target funds to local substance abuse priorities by a) improving, monitoring, and complying with Block Grant requirements, and b) testing outcome measures associated with reducing alcohol and drug abuse.

Measures: Standard measures will be applied to this activity where possible. It is important to recognize that there are few prevention requirements imposed by the SAPT block grant legislation and therefore CSAP has little direct control over the intermediate and long term outcomes. As States move toward consensus regarding common use and reporting of outcome data, CSAP will transition toward performance measures that will reflect those agreements.

Program update/performance report: States vary widely in the extensiveness and scope of their prevention services. While some depend entirely on the 20% set-aside for supporting their prevention programs and activities, others use these funds to fill major gaps in their programs and enrich others for greater impact. CSAP continues to use the funds allocated to it under the set-aside for providing States useful support services for making optimal use of the set-aside funds under the Substance Abuse Prevention and Treatment Block Grant as well as their State and foundation funds dedicated to prevention activities. One of the most significant impacts of CSAP's efforts is to generate synergistic effects of bringing States together around common problems with solutions specific to their own special conditions. Another special feature of this approach is to raise the level of functioning and effectiveness of States which are less advanced than others.

#### **Measure 1: Increase the percentage of States that will incorporate needs/ resource assessment data into intended use plan in the block grant application**

Rationale: Scientific findings from State needs assessment studies must be operationalized into resource allocation and strategy selection choices. This is not only important from the point of accountability but is an indicator of continuing quality improvement in services and their impacts.

Data source: Block Grant application.

FY 1998 baseline: To be available in FY 1999.

Program update: As the number of States with adequate funds for needs assessment and data infrastructure (see FY 2000 initiative) increases, their ability to incorporate those data into their block grant applications will increase correspondingly.

#### **Measure 2: Increase the percentage of States that will apply block grant funds to activities in each of the six prevention strategy areas.**

Rationale: Substance abuse prevention research literature strongly suggests that just as there is multifactorial causation of substance abuse, in order to be effective, prevention activities have to be multifaceted, repetitive and increasing in dosage. Thus, State programs with block grant-funded interventions distributed in each of the legislatively indicated six strategy areas are more likely to achieve a comprehensive prevention program and are motivated to work in that direction.

Data source: Block grant application.

FY 1998 baseline: To be available in FY 1999.

Progress update: CSAP has been working closely with the States in helping them meet this block grant requirement.

#### **Measure 3: 90% of states will provide a satisfactory rating of TA services received within prior two years.**

Rationale: Technical assistance that is appropriately designed, marketed, and targeted will meet State needs and will serve to enhance local prevention efforts. To varying degrees, States need assistance in putting to effective use available science-based reports, studies, and analyses. Most of such literature is written by researchers for researchers and exists in locations/sources that are unfamiliar or not easily accessible. There is a great need for such materials to be translated and transformed into educational materials which are user-friendly and disseminate them effectively.

Program update: The technical assistance structure is being examined for improvements which will enable CSAP to meet the above target.

Data source: Customer satisfaction survey  
FY 1997 baseline: 90%, with 60% responding.

**Measure 4: Identify 5 potential prevention performance outcome measures through the minimum data set activity, and complete testing in at least 11 States (FY 1999 target).**

Rationale: The identification of performance measures for mental health and substance abuse has been identified as a critical need. These measures will ultimately become SAMHSA's block grant-related performance measures. The measures will not change from FY 1999 because the subsequent activities will be focused on evaluating and modifying the pilot system and deploying it nationally.

Program update/performance report: A minimum data set (MDS) initiative is underway to assist States and CSAP in the development, implementation, and application of a State uniform performance monitoring and measurement system. Eleven States participated in the Phase I pilot of the program, which focuses on process measures and services data. A collaborative effort resulted in agreement on data items, definitions, methods of data collection, the development of a PC based software system, and technical assistance related to training and installation. At last report, data were currently being collected at the program level and aggregated at the sub-State and State levels by seven States, seven more States were in the process of implementing the system either by pilot testing the system with a subset of their providers or going directly Statewide, and twenty-three additional States had requested technical assistance in the form of briefings and/or training in order to evaluate the system. Once sufficient data have been collected, participating States can use the results to allocate resources and improve State planning for prevention programs. Phase I data will be provided to CSAP for analysis and aggregation at the national level, which will provide important information about the number and types of prevention services provided and populations served..

Phase II focuses on intermediate and long term outcome measures and is expected to be completed in 1999. These measures will be field tested in the SIG States as part of their broader core measures for their feasibility for use in future block grant reporting. At the same time as planning and design of Phase II progresses, a considerably more advanced Phase I software system is being planned. This would significantly reduce the cost and time of developing an entirely new product and yet provide States and CSAP data and functions that would not otherwise be available for several years. Several States are currently developing technology that if integrated or linked could create a comprehensive and powerful State and national prevention expert system from needs assessment to performance measurement. These technologies are being considered and discussed in relation to CSAP's core measures initiative and their future promise in helping the field improve their accountability systems.

FY 1997 baseline: 0 performance measures were tested.

Data source/validity of data: States=information systems and surveys of states. Reliability and validity will be assessed in the feasibility phase.

Program update: We expect to achieve this target in FY 2000. Indicators have been incorporated in the core measures that are being used by the State Incentive grantees.

**b. State Incentive Grants (a component of YSAPI)**

Goal: The State Incentive Grant (SIG) program of the Center for Substance Abuse Prevention (CSAP) has a twofold purpose and related goals:

- C      Governors should coordinate, leverage and/or redirect, as appropriate and legally permissible, all substance abuse prevention resources (funding streams and programs) within the state that are directed at communities, families, youth, schools and workplaces in order to fill gaps with effective and promising prevention approaches targeted to marijuana and other drug use by youth.
  
- C      States should develop a revitalized, comprehensive statewide strategy aimed at reducing drug use by youth through the implementation of promising community-based prevention efforts derived from sound scientific research findings.

Program update/performance report: States have agreed on the use of core data to be collected across sites at the State, subrecipient and program levels. States are also reaching agreement on the instrumentation that will be used to collect those data (both process and outcome.) From these core measures, SIG States will also field test several for their feasibility and usefulness in Block Grant application reporting. The SIG evaluation framework articulates the program theory or logic model upon which the SIG program will develop its structural elements and deploy its general intervention strategies. The framework represents assumptions and causal expectations about how SIG program activities align to produce the desired outcome of a revitalized, coordinated and comprehensive prevention infrastructure within a State: (1) SIG mobilization; (2) State-level system characteristics/dynamics; (3) sub-recipient characteristics/dynamics; (4) State-level collaborative strategies/activities; (5) sub-recipient planning/science-based prevention interventions; (6) State-level immediate outcomes; (7) sub-recipient immediate local outcomes; (8) State-level systems change; (9) intermediate outcomes (risk and protective factors); (10) long-term outcomes (behavioral impacts); (11) contextual conditions (economic, cultural). For example:

Long-term outcomes: Substance use

Constructs	Indicators	Data sources	Instruments/measures
Alcohol use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey item Youth risk behavior survey item Household survey
	Binge drinking	Youth survey	Seven state consortium survey item Youth risk behavior survey
Tobacco use (cigarettes)	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey item Youth risk behavior survey Household survey
Marijuana use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey Youth risk behavior survey Household survey
Other illicit drugs	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey Youth risk behavior survey Household survey

The bottom line impact of interest for the SIG projects is the reduction of alcohol, tobacco and illicit drug use in the target populations of the local sub-recipient communities. Many of the individual SIG grantees have other long-term, health-related outcomes of interest: reductions in juvenile delinquency, teen pregnancy, violent behavior, etc. across the five grantees, however, there were several outcomes in common: alcohol use; tobacco (smoking) use; marijuana use; and other illicit drug use. In general, measures of actual use of each of the substances listed above included

four primary indicators: lifetime use, annual use, 30-day use, and age of first use. Finally, the importance of evaluation in this far-reaching CSAP initiative has been abundantly emphasized at all levels. SIG grantees have responded to this with their own detailed plans and willingness to compromise on behalf of the national agenda.

**Measure 1: Increase State level collaboration rating from the 1998 baseline**

Rationale: The States receiving SIGs are developing new substance abuse prevention systems through collaboration with other State agencies and the combining and leveraging of resources and dollars. Over the 3 years of funding, each State will document and evaluate this new prevention system and do qualitative comparisons with the ~~old~~ prevention system. Collaboration will be rated using a survey being developed jointly by the initial cohort of SIG grantee states. Data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

FY 1998 baseline: SIG States have completed their instrument development and will be collecting the data over the next months. Cross-site analysis will determine the average level of collaboration across the program. Baseline data to be available in FY 1999.

FY 2000 Target: To be determined when baseline data are available.

Data source/validity of data: States have agreed on the use of the same instruments and types of data to be collected. Data will be collected through several mechanisms: State grantees, subrecipients (local community or provider project level) and through school and community-based surveys. Data will be sent to a CSAP data retrieval system for entry and documentation.

Progress update: The first cohort of States has identified the factors that contribute to state level collaboration and developed a draft survey that will be administered to state agency representatives. SIG grantees will employ a standard approach to identifying the top five State agencies in their State and will use a common State agency collaboration interview to measure the frequency and extent of collaboration among these five top State agencies.

**Measure 2: In FY 2000, past month substance use will decrease by 15% among youth ages 12-17 from the baseline (YSAPI measure)**

Rationale: States will be measuring the reduction in youth substance abuse via State level measures, community level measures, and specific program measures to determine the effectiveness of science based prevention programs and the effectiveness of the new prevention system. The decrease in risk indicators will also be examined. These and other data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

FY 1998 baseline: To be available in FY 1999.

Data source/validity of data: The NHSDA, a national survey with known and established reliability and validity, will be used, as well as individual State school surveys. Program data are not yet available.

Progress update: States have agreed to include the same items to measure this variable across State sites at all levels of analysis (State, community, program). This is a major forward step in moving towards State core performance measures. While the NHSDA can provide indirect State estimates (in most cases); the State surveys will be especially helpful by allowing analysis at lower levels (regional, local, program).

**c. CSAP Community Coalitions Program**

Goal: To increase community involvement in dealing with problems of substance abuse and its attendant effects; to promote the development of infrastructure in communities for initiating and facilitating substance abuse prevention activities.

Measures: This program has been completed, so existing measures will be utilized to report results.

Program update/performance report: Final analysis of the data collected as part of the national evaluation of the

community partnership program is complete and efforts to disseminate the findings from the evaluation continue. Residential and school surveys, over two points in time, showed that 24 representative partnership communities as a group were associated with lower rates of substance abuse, relative to 24 matched comparison communities as a group. Of the 12 measured outcomes (covering alcohol or illicit drug use for each of the three age groups -- adults, 10th graders, and 8th graders, in the past month and the past year), only adults=alcohol use for the past month was statistically significant. For the partnership communities, male substance abuse rates were lower at the second point in time, relative to the comparison communities - usually by about three percent - on five out of the six outcomes: adult illicit drug use and alcohol use in the past month; 10th grade illicit drug use in the past month; and 8th grade illicit drug use and alcohol use in the past month (all comparisons were statistically significant). In contrast, female substance abuse rates were significantly different for only one of the six outcomes, and the partnership communities= rates were higher for 8th grade illicit drug use in the past month. When the responses for males and females were combined, only one of the six outcomes was significantly different, and favored the partnerships.

When comparing individual partnerships with their paired comparison communities, 8 out of 24 partnerships showed statistically significant reductions in substance abuse. The surveys also revealed other statistically significant findings associating partnerships with the following outcomes:

Adults who report less illicit drug use also reported being in a partnership community (not comparison community); being more involved in prevention activities; living in a *Agood@neighborhood* (i.e., - a neighborhood free from drugs); and having a disapproving attitude toward drugs. The study showed that gaining community involvement and recruiting and involving members in all aspects of community infrastructure building and prevention program implementation were significantly related to attaining the partnerships=stated prevention goals. The study also identified several characteristics that were exhibited by those partnerships that had statistically significant reductions in substance abuse: a comprehensive vision that covers all segments of the community and all aspects of community life; widely shared vision that reflects the consensus of diverse groups and citizens throughout the community; a strong core of committed partners at the outset of the partnership; an inclusive and broad-based membership with participation of groups from all parts of the community; avoidance or resolution of severe conflict that might reflect misunderstanding about a partnership's basic purpose; decentralized units within a partnership that encourage implementing prevention programs in small areas within a partnership and that empower residents to take action and make decisions; low staff turnover that, when it happens, is not disruptive; and extensive prevention activities and support for local prevention policies, reaching a large number of people for an extended period of time.

The Coalition program evaluation is using a time series design of archival data indicators. Complete data are expected for next year's report. Preliminary results of analyzing trends in the health and the fatal accident indicators between 1992 and 1996 show no substantial differences between the coalitions and their matched comparison sites during the early implementation period of the community coalitions program. This is not surprising, given the conceptual framework model, which posits that a series of steps must occur between program implementation and the realization of the long-term program goals of reducing substance abuse and its related consequences. It was also observed that formally organized coalitions claimed more prevention outcomes than informally organized coalitions. Future plans include relating these coalition characteristics with the results of the analyses of the archival data.

**Measure 1: Increase the mean number of organizations participating in coalition activities by 40%.**

Rationale: Infrastructure development institutionalizes knowledge intended to be practiced through the community coalitions program, increasing the probability that its positive effects will last after the coalition is formed and its prevention programs are initiated. CSAP- supported community coalitions are required to have a minimum of two partnerships, and state-coordinated coalitions are required to have a minimum of three partnerships. A partnership is defined as a formally structured group of no fewer than seven (7) official member entities. During the first year of funding CFY 1995C the number of partners in each coalition ranged from 2 to more than 50, with a mean of 6.3 partnerships in each coalition. As coalitions develop over the course of the grant period, both the number of community organizations and the number of partnerships participating in coalition activities is expected to increase.

FY 1995 baseline: mean of 46 organizations participating in coalition activities.

Data source: CMIF

Program update: The preliminary analysis of the process variables indicate that the coalitions have been involving an

increasing number of organizations in the coalitions and have been increasing the extent to which they have adopted formal procedures such as having an governing board with elected officers and having formal operating procedures. For example, the mean number of organizations participating in coalition activities has increased from the baseline (measure 1) of 46 in 1995, to 172 in 1997; an increase far exceeding the target of 40%. Preliminary data analysis indicates that in 1998, the mean number of organizations participating in coalitions has increased even more to 186.

**Measure 2: Increase prevention services that promote the coalition=s substance abuse prevention efforts by 100% from the base year.**

Rationale: In 1995, the coalitions were starting and getting organized. Over the course of the grant period, the coalitions will complete assessments to identify needed prevention services, develop plans to meet those needs, and implement the plans. This is likely leads to an increase in substance abuse prevention services. Rates are not expected to increase during the last years of the funding period due to increased attention on evaluation activities during that period.

FY 1995 baseline: 595 prevention programs and services coordinated and implemented by 123 community coalitions. Data source: CMIF. Information is verified via site visits, monitoring activities, and other reports.

Program update: The coalitions have surpassed all expectations for measure 2. For example, FY 1997 data show that 1803 prevention programs and services were facilitated and newly created; an increase of approximately 300% (rather than the 100% targeted). Preliminary analysis of 1998 data indicate that 2297 programs and services have been facilitated and/or created thus showing similar progress.

**d. Synar Amendment (Section 1926) Implementation activities**

Program goal: To reduce the sales rate of tobacco products to minors in all States.

Measures: This program will be examined for the feasibility of transition to new measures; in addition, the measures shown will be used.

Program update: All states have enacted such legislation. States are working (with supportive technical assistance) to establish and improve their data collection and enforcement procedures to comply with Synar regulations. Coordination with CDC and FDA continues.

**Measure 1: In FY 2000, eight additional States (4 more than the 1999 target) will reduce their tobacco violation sales rates to minors to a maximum of 20%, making a total of twelve states at or below 20%. (FY 1999 target: increase to a total of eight States)**

Rationale: Research evidence indicates that only consistent and vigorous enforcement of Sate tobacco access laws will reduce the sales of tobacco products to minors to 20% or less, and that through rigorous enforcement, all States can achieve that goal by September 30, 2003.

Baseline: The FY 1997 baseline for States with violation rates at or below 20 percent was four.

Data source/validity of data: The data source is the Synar report which is a part of the SAPT block grant application submitted annually by each State. The validity and reliability of the data are expected to be high in view of the TA being provided, the number of random unannounced surveys being conducted, and the confirmation of the data by scientific experts, site visits and other similar steps.

**Measure 2: Maintain at 100% the proportion of States provided with periodic technical assistance in implementation of guidelines to meet Synar goals.**

Rationale: CSAP is in a unique position to provide leadership and guidance to States on overcoming barriers to developing appropriate sample designs and other technical materials, based on scientific literature and demonstrated

best practices, for the effective implementation of Synar. The FY 1999 measure of 100% will be maintained.

FY 1998 baseline: In FY 1997, twelve States received technical assistance in implementing the guidelines to meet the Synar goals.

Data source/validity of data: The data sources for the baseline and measures were derived from State project officers= logs and organizations who were awarded State TA contracts. The analysis will be based upon the actual requests/responses received, thereby providing a high degree of reliability and validity.

**Goal 1: Bridge the gap between knowledge and practice**

**a. CSAP Prevention Intervention Studies on Predictor Variables by Developmental Stages**

Goal: To generate new empirical knowledge about effective approaches for changing the developmental trajectory of children at risk of substance abuse.

Program update/performance report: Interventions are proceeding as planned. The results of this cross-site analysis are expected in October 1998. The Predictor Variables Program is in its second year. The following site example demonstrates the type of quantitative results anticipated once the program analyses are completed:

Phase I (summer, 1997): Program design used a 7-week highly intensive and focused behavioral interventions, a social skills training component in natural settings with peer group and dyadic experiences, and structured opportunities for sports/hobbies skills training and recreational activities designed to create an overall positive experience for the child.

Hyperactivity	Exp		Control		Manova f	time	t x group
	mean	sd	mean	sd			
pre	2.51	.78	2.33	.63			
post		2.25		2.30	.70	6.8*	4.3*

\*p< .05, \*\*p < .01, \*\*\*p <.001

Aggressive/ Disruptive	Exp		Control		Manova f	time	t x group
	mean	sd	mean	sd			
pre	1.72	.32	1.68	.42			
post	1.55	.32	1.60	.34		33.7***	4.4*

\*p< .05, \*\*p < .01, \*\*\*p <.001

Concentration Problems	Exp		Control		Manova f	time	t x group
	mean	sd	mean	sd			
Pre	2.27	.43	2.22	.49			
Post		2.00		2.12	.44	34.7***	7.4**

\*p< .05, \*\*p < .01, \*\*\*p <.001

Higher scores indicate greater severity of problem

In addition, the experimental group showed significant improvements on measures of social adjustment, including task orientation, frustration tolerance, assertive skills and peer social skills. Also noteworthy were school attendance rates that exceeded 90% throughout the summer program and high rates of parent participation at scheduled parent night activities [ n=240 (100%) at the final parent night]. Approximately 95% of the parents expressed desire to continue with the early risers program.

Implication: children with early-starting aggressive and disruptive behavior are at heightened risk for the development of alcohol and drug abuse. As a consequence of their aggressive behavior they underachieve in

schoolwork, are rejected by their peers, enter into coercive interactions with their parents and siblings, and develop low self esteem. Improvement in self regulation of behavior is considered essential first step to the prevention of later substance abuse.

**Measure 1: 80% of sites (8) will implement effective intervention models for all populations designed to be disseminated through professional journals and meetings in the field of prevention (FY 1999 target; end of grant period).**

Rationale: Aside from generating findings on the effectiveness of the interventions and determining the impact of each of the four predictor variables on children and parents, this program expects to generate intervention models that can be disseminated to state and local communities interested in implementing age appropriate substance abuse prevention programs. These programs are for all populations including those children at risk for substance abuse that have been identified by previous demonstration grant programs, (e.g., the child development project (grant # 1H86SPO2647) a five-year initiative, 1991). These studies will end unless funds are made available for further competitive funding to continue them as longitudinal studies.

FY 1998 baseline: 0 sites (10 grant sites received initial awards in 1997).

Progress update: All sites have collected and submitted baseline data to the research coordinating center for analyses. Several of the programs have collected intervention data and are starting to generate preliminary findings. Following are examples of promising significant findings submitted by individual sites:

- C Preliminary analyses indicate significant improvements in children's aggressive behavior placing them at less risk for future substance use.
  
- C Preliminary findings that showed significant improvement when compared to the control groups were made in the areas of: improved parenting behaviors (parenting ability, utilization of discipline techniques), increased family cohesion, increased family organization and decreased family conflict. Furthermore in relationship to children's behavior, statistically significant improvements, when compared to the control groups, were made in improved self control, improved cooperation, improved social competencies (as measured by the early elementary behavior rating scale) and decreased conduct problems.

Based on the above preliminary findings, we anticipate that we will be able to meet our target for Measure 1.

Data source: final reports

**Measure 2: Children 9 years of age and over in the treatment groups will show percentage decreases in alcohol, tobacco, and drug use when compared to children in the comparison group (FY 1999 target; end of grant period).**

Rationale: Intervention research has provided indications that it may be possible to change disordered behavioral patterns of young children if interventions begin early and are targeted at several predictor variables including social competence, self regulation, school bonding and academic achievement and caregiver investment. As previously described, research studies have found these indicators to be highly predictive of use. It is anticipated that this initiative will be successful in changing this developmental path toward deviant behavior and lead to more healthy social and emotional development as well as reduce the incidence of substance abuse disorders.

FY 1999 target: to be established by mid-FY 1999.

Baseline:

TOBACCO USE	2.5%	7.5%
ALCOHOL USE	4.5%	8.3%
MARIJUANA USE	.8%	2.3%
TOTAL USE	7%	13.3%

Data source: Sites in this program must use standardized and validated instruments. Results must be reported in the final report. Accuracy of results can be verified from re-examination of raw data and quality control procedures.

Progress update: Based on the preliminary data described above, and the proven association of these factors with substance use, we anticipate results of the final cross-site analysis to yield findings that demonstrate success in achieving our target for Measure 2.

### **b. Starting Early/Starting Smart: Early Childhood Collaboration Project**

Goal: To test the effectiveness of integrating mental health and substance abuse prevention and treatment services (behavioral health services), for children ages birth to seven years and their families/care givers, with primary health care service settings or early childhood service settings.

Measures: Performance measures have been revised to remove unnecessary process measures and to reflect the types of data that will be received, and the baseline data which have been received. This FY 1997 program will be examined for feasibility of transition to new measures; meanwhile, the revised program-specific measures shown below will be applied. Core measures include extent and normative comparisons of key measures in each of 4 areas. Some examples include :

- I. Parental functioning: Parental substance abuse; Parental mental health status
- II. Child functioning: Health status; Language development; School readiness; Social functioning; Behavior
- III. Parent-child dyad: Parental discipline; Bonding
- IV. Service integration: Inter/intra-staff contacts; Appropriate service utilization

Program update/performance report: Because the dollars are awarded as cooperative agreements, an invigorated partnership has been developing, now involving 12 community grantees, and a data coordinating center. Throughout the first nine months of this project (Phase I) they have been working collaboratively to design the cross-site research design, using core measures across sites, which can best develop critical new knowledge for the early intervention field.

**Measure 1: SAMHSA and 100% of the federal and private partners to this effort will have executed memoranda of understanding (MOU) that specify their mutual expectations (FY 1999 target).**

Rationale: One of the goals of SESS is to foster public/private collaborations to create a more comprehensive framework for improving services to young children and their families. Collaborations across government agencies and private sector organizations promote systems integration and streamline the process for providing services.

FY 1997 baseline: 50 percent of the collaborators have MOUs.

Data source/validity of data: CSAP records substantiating the execution of these official agreements. This measure will be dropped once its target is achieved.

Progress update: Due to the collaborative environment described above, we expect to achieve our target of 100% execution of our MOUs with our federal and private partners.

**Measure 2: Establish baseline data on physical health, behavior, social and emotional functioning and language development of participating children ages 0 - 5 by compilation and analysis of collected data from the**

**initial administration of the determined protocol instruments (FY 1999 target; measure will be revised to set FY 2000 targets once baseline data are collected).**

FY 1997 baseline: Baseline data to be available in FY 1999.

Data source/validity of data: Multiple selected, sometimes modified, standardized instruments, agreed upon by consensus of the steering committee, are used.

Progress update: As previously described, the collaborative environmental context of the SESS project has enabled its partners to agree in FY 1998 on the core measures and instruments to be used across sites. Therefore, we do not anticipate a problem in achieving our goal of establishing baseline data on those measures.

### **c. Youth Connect - High Risk Youth Mentoring/Advocacy Program**

NOTE: This Knowledge Development program is supported by the High Risk Youth budget activity.

Goal: Youth Connect is a knowledge development (KD) program that seeks to prevent or reduce substance abuse or delay its onset in youth, 9-15 years of age by improving 1) school bonding and academic performance, 2) family bonding and functioning and, 3) life management skills.

Measures: Standard measures will be identified and applied to this activity following award. In addition, the program-specific measures listed below will be applied. The outcomes associated with Across Ages for study participants relative to no-treatment controls include:

- C mentored youth (mps) and the limited treatment group (ps) had fewer days absent
- C mps youth demonstrated improvement in their attitudes towards the future, school and elders.
- C mps youth demonstrated large gains in their knowledge/ perceived ability to respond appropriately to situations involving drug use.
- C mps youth gained more knowledge than ps and comparison youth of community issues.
- C mps youth with exceptionally involved mentors (higher dosage), in comparison to those with average or marginally involved mentors, gained knowledge about the potential risks and consequences of substance use, increased perceived ability to respond appropriately to situations involving drug use, and reduced school absenteeism.

Based on findings from previous CSAP activities (see example above), CSAP will evaluate the effectiveness of mentoring interventions with diverse programs that employ professional and paid mentor/advocates, who will be required to spend an extensive and specific amount of time with their mentees and/or their families/caregivers. CSAP wants to determine the effectiveness of mentor/advocates with youth-alone versus youth with their families. It is anticipated that this intervention will be effective in reducing substance abuse and related violence, as well as improving community attitudes about youth and enhancing the system of support available to them and their families. Mentoring programs are of interest to ONDCP and individual States as well as CSAP

Program update/performance report: Awards were made in FY 1998 to 15 study sites and a coordinating center that is charged with the responsibility of working with these grantees to determine core data sets, coordinating an evaluation across sites, and ensuring the integrity of the data.

**Measure 1: A decrease of 10% in the rates of substance abuse and related violence for treatment subjects relative to similar populations not receiving comparable prevention programming (FY 2000 target).**

Rationale: Prior research has demonstrated that improving school bonding and academic performance, improving family bonding and functioning, and improving individual life skills can serve as protective factors to prevent youths' abuse of substances. This initiative targets collection of individual data for treatment and comparison groups to determine the success of the interventions in positively affecting these areas.

Baseline: All funded project sites submit baseline and annually collected data to the data coordinating center which, in turn, analyzes and submits the cross-site data to CSAP; all baseline data are anticipated to be generated in FY 1999 and available in FY 2000.

Data source: Data will be collected on sociodemographic characteristics, children's interactions with their parents/caregivers and other family members as well as school and community. The steering committee will begin a selection of a core set of instruments to be used across sites. It is anticipated that measures will be collected on how the prevention intervention and associated services can be effective in preventing, delaying and/or reducing his/her substance abuse, improving school bonding and academic performance, improving family bonding and family relationships and improving life management skills. Implementation or proximal measures of outcomes should include frequency, level of subject participation etc.

**Measure 2: 60% of sites will be able to document models that are determined to be both effective and replicable (FY 2000 target).**

Rationale: in addition to providing findings on effectiveness, it is expected that these studies will produce replicable models that can be disseminated to state and local communities interested in implementing effective mentoring/advocacy programs.

Baseline: Baseline data to be available in FY 1999.

Data source: All instruments will be reviewed and chosen at the first steering committee meeting.. Models will be fully documented with both qualitative and quantitative data and will include face-to-face interviews, surveys, paper and pencil written questionnaires, psychological testing, administrative records and participant observation.

**d. Cooperative Agreements for Public/private Sector Workplace Models and Strategies for the Incorporation of Substance Abuse Prevention and Early Intervention Initiatives into Managed Care (short title: Workplace Managed Care)**

Goal: The overall goal of this cooperative agreement program is to determine which public/private sector workplace managed care substance abuse prevention and early intervention programs are the most effective in reducing the incidence and prevalence of substance abuse and to disseminate these findings. Objectives are: (1) to determine the nature (e.g. structure, organization, function, etc.) of workplace managed care (WMC) programs utilizing substance abuse prevention and early intervention efforts; and (2) to provide a detailed description of the WMC programs; assess their strengths and weaknesses and their impact on the substance abuse of employees and their families (e.g. covered lives); and assess the quality and delivery of substance abuse prevention and early intervention.

Measures: This program will be examined for feasibility of transition to new measures in addition to the measures presented below.

Baselines and targets: To be determined by the end of FY 1998.

Data sources: Employer and health care organization records; cross-site program survey to be developed.

Program update/performance report: A steering committee, composed of grantees, the coordinating center and CSAP has developed research questions and core measures for answering them.

**Measure 1: CSAP and the 9 funded cooperative agreements will agree to core process and outcome measures for the cross-site analysis (FY 1999 target).**

Rationale: One of the goals of the WMC program is to complete a cross-site analysis of the funded cooperative agreements and to be able to study findings across the sites.

FY 1998 baseline: No consensus at program start across sites.

Data source: CSAP records, grant reports, WMC cross-site database

Progress update: CSAP and the nine funded cooperative agreements have agreed on core outcome measures for the cross-site analysis. Consensus is expected in early 1999 regarding the core process measures. By December, 1998, retrospective data have been provided by two grantees and baseline data were provided by eight grantees.

Retrospective data should include: human resource, employee assistance program (EAP)/family and employee assistance program (FEAP), and claims data.

During Phase I of the study the nine study site evaluation teams focused their efforts in gaining full understanding and knowledge of their collaborating worksites and the prevention/early intervention strategies implemented within these worksites. . To date, all nine grantees have submitted their logic models to the coordinating center for review. Phase II of the study has focused on developing the WMC core data set. At present, the steering committee has reached a consensus on the common elements of the core data set to answer many of the programs main outcome questions. The core data set includes records based data from the worksite, EAP, MCO, and other participating entities. For a subset of the participating study sites, workplace employee surveys will also be administered to collect data to be analyzed as part of the cross-site initiative.

**Measure 2: Health care utilization will increase as defined by pre-post intervention in prospective studies (FY 2000 target)**

Rationale: Research indicates that there are a number of intervening and outcome variables obtainable through health claims data which are important in studying the success of substance abuse prevention and early intervention programs in workplace managed care settings. Intervening variables including data of birth, sex, marital status are important to interpreting the data. Utilization and cost of emergency room services, utilization and cost of urgent/emergency room services; utilization and cost of outpatient services; utilization and cost of inpatient services; utilization and cost of substance abuse services and related medical conditions; utilization and cost of mental health services, have been shown to be good predictors of the success of the substance abuse prevention/early intervention programs. Health care utilization indicators include the relationship to subscriber, plan enrollment and disenrollment dates, location of service, cost of service, and ICD-0 diagnosis codes will be used across the nine sites. Financial outcome data have also been shown to be good predictors of the success of substance abuse prevention/early intervention programs however the exact measures have not yet been finalized.

Baseline and target: To be defined.

Data sources: Employer and health care organization records; program survey is being developed.

Progress update: Grantees are beginning to collect retrospective data and baseline data including: medical and mental health utilization and costs, drug testing data and costs, and human resource data from secondary sources. All nine funded grantees are currently preparing linkage files (human resources, employee assistance program, claims data, survey data) to send collected data for the cross site evaluation. Some preliminary evidence includes:

- C G-4 has collected workers' compensation claims, health care costs by 14 sites for 1996-1997 for more than 1,300 employees indicating combined number of claims of 287 with a range of 0 - 35.1% filing for the two years combined and healthcare costs of \$708,053 for these claims. It built a retrospective database for 96 variables including drug testing and is completing its analysis.
- C G-8 has completed creating its alcohol abuse prevention web site to assess employee's risk for alcohol abuse/dependence which is designed as a prospective intervention; and analyzed retrospective health care utilization data. They found for 1997 there were 28,765 covered lives with a prevalence of .118% having substance abuse treatment needs. Preliminary analysis of OSHA 200 logs suggest 7.5% of the cases are alcohol-related.

The retrospective data will provide information and insight on the intervention strategies implemented at each worksite prior to the onset of the WMC study. The data collection schedule for the HR, MCO, EAP record-based

data is expected once all test file procedures are complete and will continue on a quarterly basis. Test files are available for four grants; the remaining files should be available early Spring, 1999.

## **Goal 2: Promote the adoption of best practices**

### **a. CSAP Clearinghouse Program**

Goal: Increase substance abuse and mental health public information dissemination activities.

Measures: Standard measures will be applied to this activity. In addition, the measures from the FY 1999 GPRA performance plan, as modified below, will be applied during the transition to the new measures.

Program update/performance report: The new NCADI contract awarded on September 25, 1998, requires 10% of the budget to be used for evaluation. Questions include such topics as customer satisfaction and whether and how requestors have used the information received. NCADI is responding to the demand generated by the ONDCP National Youth Anti-Drug Media Campaign, which has stimulated twice the level of demand as compared to last year. Also, NCADI has moved into call center operations 24 hours a day, 7 days a week, to serve the ONDCP media campaign as well as various CSAP public education campaigns (which have been adopted by the DHHS Secretary's Office), and has taken on responsibility for CSAT's National Treatment Helpline.

**Measure 1: By FY 2000, increase the number of information requests received annually by 10% over the FY 1997 baseline (FY 1999 target: 5% over FY 1997 baseline).**

Rationale: The distribution of SAMHSA/CSAP/CSAT, NIAAA, NIDA, Department of Education, Department of Labor, and other organizational print and audiovisual resources to the prevention, intervention, and treatment field is a standard measure for gauging the responsiveness to the public's need for information.

Items to be measured and reported include:

- C the frequency of use of the following services of NCADI will increase by 5%: telephone; mail; PREVLIN website ([www.health.org](http://www.health.org)); staff, walk-in visitors;
- C related to the ONDCP media campaign in 1998, where did the requestor get the 800 number? when did the requestor see/hear the advertisement? is the requestor getting materials to help talk with a child about substance abuse?

FY 1997 baseline: telephone: 13,750 requests per month; mail: 2,750 requests per month; Prevlina: 1,100 requests per month; staff, walk-in visitors: 733 requests per month

Data source/validity of data: The NCADI contract has several tracking systems in place to account for the processing of phone calls, mail, e-mail, staff requests, and visitors. Each of these measures is reported to CSAP on a monthly basis and includes analyses of trends over time.

Program update: The current level of demand for NCADI services during a typical month is reflected in the following profile: 19,166 requests/month; 82 percent of inquiries are made by phone (523 calls/day); 8 percent by mail (51 orders daily); 8 percent by e-mail (51 electronic orders daily); and 2 percent by fax/in-person. The ONDCP National Youth Anti-drug Media Campaign, which was launched July 9, 1998, has had a significant impact on the number of calls to NCADI. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Historical records indicate that caller volume increases steadily each year regardless of whether broad-based media efforts are implemented. As of December 1998, ONDCP campaign's media efforts has stimulated a doubling in demand for substance abuse information. Compared to the same timeframe in July last year, the increase in NCADI caller volume is 220 percent. This increased level of caller volume is expected to continue to escalate dramatically as the ONDCP media campaign expands its efforts.

**Measure 2: In FY 2000, customer satisfaction will remain high (at least 85%). (FY 1999 target: customer satisfaction will remain high at 85%).**

Rationale: This measure offers direct feedback on the experience of customers trying to access and use clearinghouse services and resources. New measures will be added as additional services are implemented.

Baseline: FY 1997 customer satisfaction rate of 85 percent. FY 1998 customer satisfaction rates have exceeded 90 percent.

Data source/validity of data: NCADI staff draws a random quality control sample from completed orders each month and customers are called on an ongoing basis during the following month. A customer service satisfaction report is generated every 6 months and submitted to CSAP. There are limitations to the data in that nonrespondents represent roughly 50% of the sample.

Program update: By FY 2000, it is expected that SAMHSA will have substantive qualitative and quantitative data on the NCADI contract's performance in areas such as customer service (e.g., courteous and timely response to requests), marketing penetration of various products and services (e.g., audience impressions of radio and print public service announcements), usage patterns of products and services (e.g., types of information being downloaded from PREVLIN), and utility of products and services (e.g., how was the information used and was it as intended). Currently, the NCADI contract has traditional tracking information (e.g., number of contacts, mode of contact, number of website hits, number of publications shipped, general customer satisfaction assessments). While helpful to describe levels of activity for the purpose of efficient resource allocation, the new NCADI contract is refining its evaluation efforts to use performance measures that more directly impact Federal program directions and activities.

#### **b. National Public Education Efforts (linked to YSAPI)**

Goal: To raise public awareness about substance abuse prevention issues, and to promote healthy changes in individual and group attitudes and behaviors.

Measures: Standard measures as well as the measures stated below will be used in this project.

Program update/performance report: There are currently three national media campaigns at various implementation phases: the Reality Check! Marijuana campaign, the Girl Power! Campaign and the Positive Activities campaign.

The **Reality Check** campaign is a multimedia campaign designed to prevent new use and reduce existing use of marijuana among 9- to 14-year olds. The *Keeping Youth Drug-Free (Guide for Parents, Grandparents, Elders, Mentors and Other Caregivers)* was the second most requested product in November 1998 at NCADI with 7,905 requests. Outreach numbers by print, television, radio and the website are listed below:

The **Girl Power!** campaign continues to build public-private partnerships at the national, state, and local levels to expand the reach of the campaign. For example, the Girl Scouts have developed a Girl Power! Girl Scouts merit badge. Working with CSAP, the Girl Scouts are developing the substance abuse prevention educational materials needed to earn this new badge. Also, grass-roots Girl Power! promotional events with celebrity spokespersons such as Dominique Dawes continue to flourish.

The **Your time -- their future** campaign, which emphasizes positive activities, targets parents and caregivers of youth ages 7-14 and is intended to encourage adults to become role models who can guide young people. CSAP launched the campaign in October 1998 with Secretary Shalala as the key spokesperson. Radio live scripts and English and Spanish video PSAs as well as supporting ancillary campaign materials are being distributed widely.

**Measure 1: In FY 2000, there will be a 5% increase in media placements and media accesses to PrevlIn and the phone system over the FY 1997 baseline.**

Rationale: Indicator for success of marketing efforts to achieve a high level of mass media penetration. This activity is used to establish and sustain relationships with a broad range of media. Placements and access can vary widely according to media coverage of substance abuse issues. Regular communications with the media results in a steady

state of placements and access and a general awareness of SAMHSA/CSAP as a primary resource for information. When media interest in the issues is high, the number of media contacts rises dramatically. One evaluation limitation is that the number of placements and access does not provide information on how well the information was received by the intended target audience.

FY 1997 baseline: 5-15 percent response rate to media outreach efforts

Data source/validity of data: The NCADI contract has several tracking systems in place to capture these data and report them to CSAP on a monthly basis.

Program update: As a component of YSAPI and as a result of ONDCP's significant investment in media approaches to prevention, we do not anticipate a problem in achieving our measure 1 target.

Final budget appropriations may impact the achievement of identified objectives and targets.

### **c. Centers for the Application of Prevention Technologies (CAPT)**

Goal: To increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their subrecipients.

Measures: This FY 1997 project will be examined for the feasibility of transition to new measures, in addition to the measures stated below. The evaluation results of the National CAPT program will indicate achievement of goals such as: increased accessibility to an application of proven substance abuse prevention strategies; expanded state and local capacity in the substance abuse prevention knowledge application process; increased access to and use of electronic methods in the region; and established regional capacity for ongoing mentoring and coaching. The National CAPT program also expects to learn about the science and art of knowledge application. For example, which delivery methods are most effective in helping communities adopt and sustain the use of science-based prevention programs, practices, and policies? What configurations of skill development and capacity-building activities produced the greatest systems change?

Program update/performance report: The CAPT grantees are finalizing their process and outcome core measures. The CAPTS together have designed an instrument to be used across sites by their State and substate customers. CAPT grantees have attended several meetings including several with their associated SIG states. Baseline data should be available by the end of FY 1999 due to the lag time between CAPT awards and SIG grants and contracts to subrecipients who will be users of the CAPT services.

**Measure 1: By FY 2000, there will be a 25% increase in the number of technical assistance contact hours and a 25% increase in the number of prevention technologies introduced to all SIGs and their subrecipients.**

Rationale: States require sound technical support to ensure that their selection of prevention strategies, programs and policies (prevention technologies) are based on scientific evidence. These regional centers are designed to provide the necessary support in conjunction with CSAP, other HHS agencies such as NIDA and NIAAA, and other departments such as Justice and Education. The intent is to increase the number of proven prevention technologies adopted at the community level; assess how well the technology transfer activities were implemented; and provide ongoing technical assistance and capacity-building to these communities to ensure their successful adoption of prevention technologies.

Baseline for FY 1998: Being established as both the State Incentive program and the CAPT program start up.

Data source/validity of data: CAPT common data evaluation set will be based on an originally developed survey of CAPT users.

Program update: To ensure that the program needs of States and communities are met, the National CAPT program tailors its capacity-building services. From the individual level through comprehensive systemic change at the community/state/regional level, the National CAPT program is committed to working together with community and

State organizations to design technical assistance and skill development services that will significantly enhance their respective prevention systems as well as the overall prevention infrastructure across the region. Because of the regional nature of the CAPTs organization, we expect that the close working relationships and responsiveness to our regional customers will result in the targeted increases described in measure 1.

**Measure 2: By FY 2000, past month substance use will decrease by 15% from the baseline among youth ages 12-17 (YSAPI measure).**

Rationale: Comprehensive public education efforts can effect a change in the perception of harm and associated drug use by youth 12-17 years old.

FY 1997 baseline: FY 1995 NHSDA rates and FY 1998 individual State rates for alcohol, illicit drugs and tobacco.

Data source/validity of data: NIDA Monitoring the Future National High School Survey and SAMHSA National Household Survey on Drug Abuse. These are national surveys with known and established reliability and validity.

Program update: To get research findings into practical use at the local level, SAMHSA/CSAP uses an integrated delivery approach (i.e., knowledge development > knowledge synthesis > knowledge dissemination > knowledge application). Initially, new research information must be synthesized and repackaged for different types of users e.g., ranging from prevention professionals to community activists (e.g. SAMHSA/CSAP's National Center for the Advancement of Prevention). Information is then disseminated through multiple communication channels e.g., print, radio, tv, Internet, exhibits, to introduce it into the prevention field ( SAMHSA's substance abuse and mental health clearinghouses, and media services). However, provision of information alone does not cause behavioral change. In order to effectively bring about changes which will significantly enhance the delivery of substance abuse prevention services at the local level, the National CAPT program's knowledge application services (i.e., applying prevention that works) complete the cycle. The CAPTs program is one of the components of the integrated and simultaneously implemented YSAPI components that together will prove successful in achieving our target in measure 2.

**Goal 4: No programs highlighted prior to FY 2000.**

## Center for Substance Abuse Treatment

Note: The table which follows lists all significant Center for Substance Abuse Treatment (CSAT) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

	First Funded	First Completed	First Reported
<u>Goal 1: Bridging the Gap</u>			
Treating Adult Marijuana Users	FY 1996	FY 1999	FY 2001
Wraparound Services	FY 1996	FY 1999	FY 2001
Managed Care/Adults	FY 1996	FY 1999	FY 2001
Homelessness Prevention	FY 1996	FY 1999	FY 2001
Managed Care/Teens	FY 1997	FY 2000	FY 2002
Criminal Justice Diversion	FY 1997	FY 2000	FY 2002
Treating Teen Marijuana Users	FY 1997	FY 2000	FY 2002
Starting Early, Starting Smart	FY 1997	FY 2001	FY 2003
Exemplary Treatment Models	FY 1998	FY 2001	FY 2003
Women and Violence	FY 1998	FY 2003	FY 2005
Treating Methamphetamine Use	FY 1998	FY 2001	FY 2003
Treating Teen Alcohol Use	FY 1998	FY 2003	FY 2005
SA/MH in Aging Populations	FY 1998	FY 2001	FY 2003
 Goal 2: Promoting the Adoption of Best Practices			
Product Develop. and Dissem.	FY 1999	ongoing	ongoing
Addiction Tech. Transfer Centers	FY 1998	ongoing	ongoing
National Leadership Institute	FY 1997	ongoing	ongoing
Community Action Grants	FY 1998	ongoing	ongoing
 Goal 3: Assure Service Availability/Meet Identified Needs			
SA P&T Block Grant	ongoing	ongoing	ongoing
Targeted Capacity Expansion	FY 1998	ongoing	ongoing
 Goal 4: Enhance System Performance			
State Treatment Needs Assessment	FY 1992	ongoing	ongoing
TOPPS	FY 1998	ongoing	ongoing

### **Goal 3: Assure services availability/Meet targeted needs**

#### **a. CSAT Substance Abuse Prevention and Treatment (SAPT) Block Grant**

Goal: The legislative purpose of the SAPT Block Grant Program is to provide funding to States in support of treatment and prevention services for persons at risk of or abusing alcohol and other drugs. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is the cornerstone of the States= substance abuse programs, accounting for 40 percent of public funds expended for treatment and prevention (FY 1995). In 19 States (FY 1997), the grant provides the majority of funding available to support substance abuse treatment services. This vital program is indispensable to State efforts to maintain viable treatment capacities and to respond to the needs of those citizens who are greatest risk for alcohol and drug abuse.

CSAT is funding activities toward the development of outcome measures to assist the States in monitoring and evaluating substance abuse treatment services. In FY 1997, CSAT awarded 14 contracts to Single State Agencies under the Treatment Outcomes and Performance Pilot Studies (TOPPS) for the purposes of determining whether or not exportable models of outcome studies could be developed. In 1997 and 1998, the Office of the Administrator and CSAT convened meetings of States with NASADAD to identify promising outcome measures. The meeting produced the following preliminary list of common domains/indicators that are under review by the SSA's. This process is being coordinated with the TOPPS II initiative.

#### Domain I - Effectiveness

##### A. Indicator Areas -Health Status

###### Suggested bases for measurement

###### 1. Physical Health

- a) Emergency Room visits
- b) Hospital admissions
- c) Hospitalization days
- d) Addictions Severity Index (ASI) health status (or equivalent)
- e) Medical outpatient visits
- f) Prenatal visits

###### 2. Mental Health

- a) Emergency Room psychiatric visits
- b) ASI psychosocial health status or equivalent
- c) Outpatient psychiatric visits
- d) Psychiatric hospitalizations
- e) Psychiatric hospitalization days

##### B. Indicator Areas - Economic self-sufficiency

###### Suggested bases for measurement:

1. Legal income
2. Employment status
3. Use of public assistance
4. School: dropouts/suspension/grades(youth only)
5. Literacy (adults only)

##### C. Indicator Areas- Social Supports and Functioning Suggested

###### Suggested bases for measurement:

1. Living arrangements
2. Arrests/Juvenile justice
3. Self report crime-days
4. Incarceration
5. Legal status
6. ASI social support indicators
7. Child welfare

D. Indicator Areas - Substance Use

Suggested bases for measurement:

1. See Treatment Episode Data Set (TEDS)
2. See Methadone Treatment Quality Assurance System (MTQAS)
3. ASI AOD use or equivalent

Domain II - Efficiency

A. Indicator Areas - Access

Suggested bases for measurement:

1. Penetration
2. Utilization
3. Wait times

B. Indicator Areas - Retention

Suggested bases for measurement:

1. Completion rates
2. Length of stay (American Medical Association rates)
3. Rule violation/discharges

C. Indicator Areas - Costs of Services

Suggested bases for measurement:

1. Unit costs
2. Episode costs

D. Indicator Areas - Appropriateness

Suggested bases for measurement:

1. To be developed

Domain III - Structure

A. Indicator Areas - Service capacity/description

Suggested bases for measurement:

1. To be developed

B. Indicator Areas - Data capabilities

Suggested bases for measurements:

1. To be developed

C. Indicator Areas - Workforce competence

Suggested bases for measurements:

1. To be developed

D. Indicator Areas - Demographics

Suggested bases for measurements:

1. To be developed

E. Indicator Areas - Client Characteristics

Suggested bases for measurements:

1. To be developed

The awardees of TOPPS pilot projects are expected to cooperatively agree on a core set of performance and outcome measures, comparable across States, piloting those measures and beginning to collect performance and outcome data in those states. As indicated earlier, once this pilot work begins producing results, they will be highlighted in our GPRA reports. In addition, we will begin moving toward incorporating them into the standard block grant reporting

forms.

Measures: Standard SAMHSA outcome measures will be applied to this program. Pilot baseline measures for outcomes will be available in FY 2000. Targets will be set at that time. In addition, several measures from the FY 1999 GPRA Performance Plan will be used during the transition to the new measures.

**Measure 1: Overarching SAMHSA outcome indicators for adults and adolescents receiving substance abuse treatment will be reported voluntarily by those states who can as part of the FY 2000 block grant applications, as follows:**

- 1) Over the past year, percent of adults receiving services increased who:
  - a. were currently employed or engaged in productive activities
  - b. had a permanent place to live in the community
  - c. had no/reduced involvement with the criminal justice system
  - d. experienced no/ reduced alcohol or illegal drug related health, behavior, or social consequences
  - e. had no past month substance abuse
  
- 2) Over the past year, percent of children/adolescents under age 18 receiving services increased who:
  - a. were attending school
  - b. were residing in a stable living environment
  - c. had no/reduced involvement in the juvenile justice system
  - d. had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds)
  - e. experienced no/reduced substance abuse related health, behavior, or social consequences

Rationale: On a voluntary basis information will be solicited in a nondirective format in the OMB approved Block Grant Application. Initial experience in FY 2000 will identify the need for additional improvements to data infrastructure.

Baseline: Baseline data will be available in the fall of 2000.

FY 2001 Target: To be developed.

Data Source/Validity of Data: Data will be reported by States indicating sources within states.

Date expected: December 2000.

**Measure 2: Develop and implement performance and outcome measures for the SAPT block grant (see also Goal 4: TOPPS)**

Rationale: The identification of performance and outcome measures for both the mental health and substance abuse block grant programs has been identified as a critical need. However, because the reporting of outcome information cannot be mandated for the block grant, the identification and acceptance of the outcome measures must be accomplished through a collaborative partnership. Such an approach requires time to implement and complete; the Treatment Outcome Pilot Projects (TOPPS) and other activities are in place to accomplish this goal. Targets in this area will, of necessity, be qualitative until a set of measures is developed and accepted by the states. After that, performance will be measured by the proportion of states submitting outcome data.

FY 1997 baseline	FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 2000 Target
0 outcome measures tested;	Outcome domains	General agreement on domains has been	Instruments will be selected and pilot-	Initial data will be collected and analyzed;

preliminary discussions held	selected; instrument selection underway	reached with the states; work is continuing	testing begun in selected states.	reliability and validity will be assessed in the participating states.
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Data Source/Validity of Data: Ultimately, each State will determine how the information is to be collected and analyzed. As with earlier performance indicators, States will report this information in the applications and the reliability and validity will be assessed through project monitoring and periodic compliance reviews.

Progress to date: Initial TOPPS projects were funded at the end of FY 1997; TOPPS II projects were funded in September, 1998. Information domains and measures have been identified and instruments for data collection are being discussed.

Baseline: Baseline data will be available in FY 2000  
 FY 2000 Target: To be developed.

Data Source/Validity of Data: State Substance Abuse systems will collect this data each year. Data accuracy will be assessed in the TOPPS II projects (see Goal 4).

Date Expected: December 2000

**Measure 3: Increase proportion of States that express satisfaction with technical assistance provided.**

Rationale: Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA's information and technical assistance efforts. A global satisfaction measure that includes these components is being developed and will be used in future years.

FY 1998 (to date)	FY 1999 Target	FY 2000 Target
See below	TBD	TBD

Data Source/Validity of Data: Data source will be a survey of the States. Reliability and validity will be assessed when the survey is developed.

Progress to date: A customer feedback system was designed and piloted with 14 States in FY 1998. Expressions of satisfaction, via informal telephone interviews conducted by staff of an independent contractor, indicated a very high degree of satisfaction with the technical assistance provided and also suggested some improvements. Based upon this feedback, setting the FY 1999 and FY 2000 target at 85% is reasonable.

**Measure 4: Increase proportion of TA events that result in appropriate systems, program, and/or practice change(s).**

Rationale: The impact of technical assistance should be measured by changes that occur (or are maintained) in those systems, programs or practices which were addressed during the course of the technical assistance activity. Technical assistance which is off-point, too esoteric for implementation, or otherwise not practical and applicable will not result in lasting improvements in the treatment system.

FY 1998 Target	FY 1998 actual (to date)	FY 1999 Target	FY 2000 Target

See below	See below	Baseline assessment	Will be set later
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Data Source/Validity of Data: Data sources which are consonant with the selected measures will be selected and the validity and quality of data available will be ascertained as part of the selection process.

Progress to date: SAMHSA, in partnership with the field, began developing appropriate measures and data sources for this activity in FY 1998 (see discussion of Theme 2 earlier) as well as a methodology to ensure that the data are gathered without significant delay or burden to the recipients of TA. With regard to the SAPT BG, a system for ongoing feedback on the impact of CSAT technical assistance resources on State systems is under development. A component of that effort will be follow-up several months after the delivery of technical assistance to determine impact. This system will generate data compatible with that developed in the SAMHSA-wide effort related to Theme 2. Targets will be set once the baseline is known--sometime in FY 1999.

**b. Targeted Capacity Expansion**

This program addresses gaps in treatment capacity by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services.

Progress Report: This activity was funded for the first time in September, 1998. Each grantee in the program will be expected to report regularly on the number of clients served, the services provided, and the outcomes of those services. The grantees will also be required to compare this data to their estimates of the need for services and to demonstrate that they were having the expected impact on the need for services. Data on the estimated numbers of clients to be served will be reported in next years report with data on the extent to which projects met those projections in the following year.

**Measure 1: Proportion of estimated clients to be served /actually served**

Rationale: This activity is intended to help communities meet unmet needs for substance abuse treatment services. The extent to which they meet those needs is one measure of the success of this program.

Baseline: Estimated numbers to be served will be available next year; a baseline will be provided the following year and a target set.

Target: To be determined.

**Measure 2: Standard SAMHSA core outcome measures**

**Goal 1: Bridge the gap between knowledge and practice**

Knowledge Development activities yield new information that can be used by the substance abuse treatment field to improve the efficiency or effectiveness of substance abuse treatment. The critical outcome of these activities is that knowledge is generated and that it is potentially useful.

**a. Treating Adult Marijuana Users**

Goal: This study is designed to enhance knowledge about treating adult abusers of marijuana - the most widely used and abused illicit substance in the United States. This study builds on previously executed clinical trials, the target population of which was predominantly male, white, and middle-class, and seeks to expand the knowledge base by determining whether or not the same brief intervention could be effective among those sub-populations that are typically found in public sector treatment facilities --i.e., both male and female, mostly minority, typically under-educated and either unemployed or under-employed.

Progress Report: The end of treatment evaluation and the 4-month evaluation have been completed. The 9-month follow-up has recently been initiated. A 12- to 15-month follow-up evaluation will be initiated in several months based on CSAT providing a small supplement. At this point this latter evaluation will be abbreviated and via telephone. It should be noted that outcomes of the Waiting List group are only determined at the 4-month follow-up evaluation.

**Measure 1: Coordinating Center will submit copies of the two clinical intervention manuals, with annotations of Alessons learned® during the conduct of the field portion of this project.**

Rationale: In addition to generating findings on the relative effectiveness (or lack thereof) of brief interventions on marijuana users, this project expects to generate one or more intervention models that can be disseminated to clinicians throughout the country (assuming that the findings are in the predicted positive direction). Two intervention manuals, and associated annotations, will be delivered. These products will be reviewed as candidates for national dissemination, expanded clinical training, and further evaluation of the impact that brief interventions might have in addressing critical treatment needs.

FY 1998 Baseline: No manuals.

FY 1999 Target: A document will be developed by September 1999.

Data Source/Validity of Data: Project records will document activities of the Coordinating Center.

Progress report: Manuals were completed in August, 1998. They are being reviewed and dissemination plans developed. Completion of this activity was accomplished ahead of schedule and will be dropped in future report.

**Measure 2 (new FY 2000): Across subpopulations, clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks of treatment.**

Rationale: As indicated above, the previous research in this area indicates that 12 weeks of treatment has better results than 6 weeks but the individuals involved in those studies did not include large number of minority or female clients. Once completed, this study will provide evidence of effectiveness across a number of important subpopulations.

FY 1998 Baseline: Baseline, end-of-treatment, and 4 month data collection have been completed but not analyzed yet.

Target: To be determined.

Data Source/Validity of Data: Data is being collected with standard instruments administered to the clients by trained interviewers.

Progress report: Interim findings should be available for next years report.

**b. Wraparound Services for Clients in Non-residential Substance Abuse Treatment Programs: Evaluating Utility and Cost effectiveness in the Context of Changes in Health Care Financing.**

Goal: This study is designed to enhance knowledge about the effects on treatment outcomes from non-residential substance abuse treatment due to provision of wrap around services (e.g., child care, advisory legal services, transportation, vocational training, educational services). If outcomes can be shown to be demonstrably improved when needs for wrap around services are metCin addition to the fundamental need for substance abuse treatmentCand if those services can also be shown to be cost-effective, then the treatment field will have credible evidence with which to negotiate for the provision of those services through managed care architectures.

Progress Report: While the data collection is still underway, some preliminary information is available.

C The most frequently used wrap-around services used were transportation, educational services, and mental

health services.

- C The individuals who used the wraparound services tended to be single (36.7%), male (55%), Caucasian (66.1% vs 30.9% African American) and high school graduates (78.9%). 53% had some criminal justice involvement and 58.2% had income from wages.
- C Predictors of acute problems from alcohol include insurance/payor difficulties, housing needs, and education needs.
- C Contrary to belief in a dual system (public and private), there are seven subsystems with little interaction: private client, employed, insured; public client, poor, without insurance; active duty military and dependents; veterans; incarcerated; community-based with criminal justice status; and other (e.g., Native Americans, rural clients).
- C Some initial assumptions changed during the study: (1) The **A**treatment system@is more an uncoordinated collection of providers; (2) The 2-tiered system of care (above) is actually a multi-tiered collection of providers serving different populations; and (3) The **A**service system@is actually a web of interagency relationships.
- C Examples of barriers include: (1) County level: interagency isolation, competition for clients and resources; agency bias against substance abuse clients; reluctance of rural counties to spend scarce county money **A**out of county@for services; (2) Program level: lack of knowledge of available services; inadequate services needs assessment; productivity emphasis discourages referral activities; long waits for services; and paperwork; services office-based, creating accessibility barriers; and (3) Client level: low client cognitive capacity and tolerance of paperwork; inability to focus on service-related needs in early recovery phase; crisis orientation; resentment at multiple assessments; perceived discrimination; lack of necessary conditions for service access (e.g., transportation); independent attitude and pride; need for external pressure for motivation.

Analyses will be continuing over the next year.

**Measure 1 (FY 1999): Coordinating Center will develop and apply statistical models.**

Rationale: The overarching goal of the program depends on the development of appropriate statistical models which are then applied to the clinical and programmatic databases.

FY 1998 Baseline: New project; not applicable.

Data Source/Validity of Data: Project records will document progress of statistical work.

Progress Report: Statistical model development is scheduled for completion no later than 30 June 1999. Application of models for core study questions will be completed no later than 30 September 1999. This measure will be dropped once completed.

**Measure 2: 100% of final reports with findings, documented databases, and statistical models are transmitted to CSAT, and the results are validated by objective review.**

Rationale: Credible scientific findings must be able to withstand scrutiny by external experts who are familiar not only with the theoretical bases of the research but who are also able to independently validate the conclusions drawn by that research.

FY 1998 Baseline: New project; not applicable.

Data Source/Validity of Data: Project records will document progress.

Progress report: Data collection is complete; data bases are partially documented; complete final report is to be

submitted to CSAT no later than 30 September 1999. This measure will be replaced in the future by the Theme 1 crosscutting measure defined earlier and will be reported on in the FY 2001 GPRA performance report.

**Measure 3: Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone (new FY 2000).**

FY 1999 Baseline: Until baseline data collection is completed, no information is available.

Target: To be determined.

Data Source/Validity of Data: Data collection with standard instruments administered to the clients by trained interviewers has just been completed.

Progress report: Baseline data should be available for next years report.

**c. Treating Teen Marijuana Users**

**Measure 1: Clients treated with all five models will have significantly reduced marijuana use but none of the treatment will be more effective than the others.**

Rationale: As indicated above, the previous research in this area indicates that all five interventions should be effective but only little evidence of their relative effectiveness exists.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: To be determined.

Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Baseline data should be available for next years report.

**d. Starting Early, Starting Smart (with CMHS and CSAP)**

Starting Early, Starting Smart, a SAMHSA-wide program, is developing and testing a comprehensive approach for at-risk families and children. In addition to the measures reported in the CSAP portion of the GPRA plan for this activity, CSAT is tracking the following measures:

**Measure 1: All members of families who are identified as substance abusers will be offered treatment.**

Rationale: One of critical risk factors for later substance abuse in children is substance abuse in the family.

FY 1999 Baseline: Per the CSAP description, data collection should begin shortly and will not be available until baseline data collection is completed.

Target: To be determined.

Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Some baseline data should be available for next years report.

**Measure 2: 50% of those family members provided substance abuse treatment will have reduced substance use at one year follow-up.**

Rationale: Experience with a range of substance abuse treatment strategies suggests that 50% of those treated

having reduced substance use is a reasonable target.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: To be determined.

Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Follow-up data will not be available before FY 2001.

## **Goal 2: Promote the adoption of best practices**

### **a. Addiction Technology Transfer Centers**

The Addiction Technology Transfer Centers (ATTCs) are a critical component of CSAT's overall strategy for promoting the adoption of best practices in substance abuse treatment. Created in FY 1993, the original ATTCs included 11 geographically dispersed grantees covering 24 States and Puerto Rico who received their final funding in FY 1997. CSAT funded a new set of 14 grantees in September, 1998 to continue this important work in a more comprehensive and integrated way.

#### **Measure 1: After an initial start-up phase, maintain training at 12,000 individuals per year**

Rationale: Historically, the ATTCs have been able to provide training to approximately 12,000 individuals each fiscal year. Given that substance abuse treatment professionals trained in the best treatment strategies available should provide more effective treatment, improving the skills of substance abuse professionals should improve the overall effectiveness of treatment.

Baseline: In FY 1997, 12,000 individuals received training from the ATTCs.

Target: Because of start-up time, the FY 1999 target is 9,000 individuals. In FY 2000, 12,000 individuals will be trained.

#### **Measure 2: Develop and implement nationally recognized standards for education and training for substance abuse treatment professionals (ONDCP Target 3.4.1)**

Rationale: Adopting uniform standards based on best practices will assure that all clients have access to well trained, effective substance abuse professionals.

Baseline: No States.

Target: All states will have adopted standards by FY 2002.

Progress Report: New activity

**Goal 4: Enhance Service System Performance**

**a. State Needs Assessment and Resource Allocation Program**

Progress Report: 40 states currently have contracts from CSAT to conduct needs assessment studies in support of their block grant planning and reporting; 23 of those states have successfully completed one round of studies and are conducting a second set at this time. The success of this ongoing program is reflected in the states ability to provide the data required by the statute.

**Measure: Proportion of BG applications which include needs assessment data from CSAT needs assessment program.**

Rationale: One of the statutory requirements for the SAPT block grant is that states base their planning for the use of BG funds on needs assessments within the state. For the past five years, CSAT has provided direct technical assistance (in dollars and personnel) to single state agencies to engage in state-based needs assessment activities. The block grant application requires that states be able to array need-for-treatment data using sub-state planning regions as the basic unit of analysis. Every state, and most territories have now received at least one award in this area, and each state which has completed a core of basic studies is encouraged to use those state-generated data sets as the basis of their block grant applications. A measure of the success of this activity is the proportion of states that do include this information; targets are based on the proportion of states who should have completed at least an initial round of needs assessment studies.

FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 2000 Target
42%	57%	65%	65%

Data Source/Validity of Data: Data will be collected via the Block Grant Application System. Validity of the data under this system is reviewed as part of the approval of funding. In addition, reviews of the data are done as part of a cyclical compliance review process required by statute.

Progress Report: The proportion of states that submitted needs assessment data as part of their applications exceeded the FY 1998 target. In the coming year, CSAT will continue to work collaboratively with the States to increase the proportion of those who have completed their initial needs assessment studies to report that data in their applications.

**b. Treatment Outcomes and Performance Pilot Studies**

Progress Report: The activity was funded in September, 1998.

**Measure 1: Reach agreement on the standardized approach within one year of funding.**

Rationale: This collaborative program between the States and CSAT will develop a standardized approach that can be used across States to monitor the outcomes of substance abuse treatment in block grant funded providers. The development of a standardized approach is the first step in the process.

FY 1998 Baseline: Agreement on domains.

Target: Standardized approach to be developed by September, 1999.

Data Source/Validity of Data: Project records will document the agreements.

**Measure 2: Number of states incorporating the standardized outcome measures into their SAPT Block Grant process**

Rationale: As an infrastructure development activity, the goal is to develop an approach that is feasible and adoptable by all of the States. Complete adoption by all States will take some time but annual progress should be monitored.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: Within one year following completion of the activity (FY 2001), eight States will have adopted the standardized approach.

Data Source/Validity of Data: Data will be collected by community-based providers using standard instruments administered to the clients by trained interviewers.

# Office of Applied Studies

## Projects

### Goal 4: Enhance service system performance

#### a. Expanded National Household Survey on Drug Abuse (NHSDA)

Goal: To provide estimates of the prevalence of substance abuse at the national level, and in the 50 States and the District of Columbia.

Program Update: A contract was awarded in FY 1998, which will ensure the availability of a data collection system in calendar year 1999.

##### Measure 1: Availability of data collection system in calendar year 1999.

Rationale: The product of this initiative will be relevant, accurate data to be used as performance measures by the Office of National Drug Control Policy and other Federal and State agencies engaged in efforts to reduce substance abuse. This requires the availability of a data collection system.

FY 98 Baseline: New initiative.

##### Measure 2: Availability and timeliness of data in calendar year 2000.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. The first data from the initiative will be collected in calendar 1999, and will be available in calendar 2000.

FY 98 Baseline: New initiative.

#### b. Drug Abuse Warning Network (DAWN)

Goal: To provide estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas.

##### Measure: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline. Once a baseline is established, specific target goals will be determined.

#### c. Drug Abuse Services Information System (DASIS)

Goal: To provide information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment.

##### Measure: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline. Once a baseline is established, specific target goals will be determined.

FY 98 baseline: Information for the baseline is not yet available.



## Office of Managed Care, Office of the Administrator

Goal: Promote the availability of effective services to persons enrolled in managed care.

### **Measure 1: Publication of nine reports on managed mental health and substance abuse services**

Rationale: As the nation's mental health and substance abuse prevention and treatment systems are being transformed by managed care, it is essential that SAMHSA track and report developments, problems, and successful projects so that successful experiments can be replicated and problems can be avoided. No authoritative, consolidated source of information exists in the Federal government or elsewhere that provides an easily accessible source of knowledge about utilization, costs, consumer and provider characteristics and outcomes from the myriad changes being introduced throughout the MH/SA field by managed care.

1998 Progress Update:

- C An actuarial study of the costs of implementing mental health and substance abuse parity coverage at varying levels of intensity of management of care published April, 1998.
- C Two evaluation studies published of legal issues in Medicaid managed behavioral health care contracts (April, 1997; April, 1998)
- C One evaluation study of legal issues in contracts between managed care organizations and community-based mental health and substance abuse agencies (April, 1998)
- C Six technical assistance publications have been published: (1) ethical issues for behavioral health care practitioners and organizations in a managed care environment; (2) risk management; (3) designing substance abuse and mental health capitation projects; (4) a guide for MH/SA providers in negotiating managed care contracts; (5) partners in change: a consumers=guide to managed care contracts; (6) a guide for providers of MH/SA services in managed care contracting.
- C Two newsletters have been published from the SAMHSA managed care tracking project, and a summary of public managed care services in each State through July 1, 1998 is under Departmental clearance review.

### **Measure 2: Coalitions of community MH/SA agencies for consumers, families, and advocates for persons who are mentally ill or substance abusers, and for State and county MH/SA and Medicaid agencies will receive training on managed MH/SA issues that they have identified as priorities, and at least 80% will report satisfaction with the training and a commitment to use their new knowledge and skills.**

Rationale: Learning from health care reforms needs to be shared, and skills taught to enable consumers, families, providers, MCOs, and purchasers to make best use of the new options that managed care makes available.

FY 1997 Baseline: Little systematic training is being done for MH/SA provider organizations, consumers and families, and joint training of State and county MH/SA and Medicaid officials; information regarding success of training is not available.

Data Source/Validity of Data: Satisfaction and commitment to use reports will be derived from a survey of participation in training offered to at least 15 state-wide coalitions of community MH/SA agencies; 15 national and state-wide coalitions of consumers, families, and advocates for persons who are mentally ill or substance abusers or who are at risk for these disorders; and all 50 State mental health, substance abuse, and Medicaid agencies.

1998 Progress Update:

- C In 1998, SAMHSA and its Centers=Offices of Managed Care have cosponsored 6 training conferences with the Institute for Behavioral Health care. Participant evaluations of the utility of the training exceed 85% satisfied or highly satisfied.
- C In June, 1998, SAMHSA is co-sponsoring two major training conferences with the Institute for Behavioral Health care: A criminal justice and managed care summit, and a summit on quality improvement and

performance standards.

- C Training on managed care procurement and contract monitoring for consumers, families, and advocates will be held in at least 20 States through 1998 using SAMHSA developed materials. A dissemination strategy has been developed that has included input from direct consumers and families who participated in developing the contracting guide.
- C A series of 20 managed care training programs for State-wide coalitions of mental health and substance abuse agencies has been set up by SAMHSA that will work with the Legal Action Center and the National Council for Community Behavioral Health care.
- C SAMHSA has scheduled four regional training programs on managed behavioral health care contracting for State MH/SA and Medicaid agencies and for County behavioral health officials through the summer and early fall, 1998.

**Measure 3: In at least ten States with active public managed MH/SA systems, representatives of consumer and family organizations contacted by the SAMHSA Public Managed Care Monitoring and Tracking Project will report satisfaction with their involvement in MC procurement, contracting and monitoring.**

Rationale: Consumers and family members have made very important contributions to Federal, State, and county MH/SA systems over the last decade. However, consumers and their advocates report being extremely frustrated by their lack of involvement in managed care systems and generally feel that their needs are not being well served. SAMHSA supports efforts to develop service systems that are responsive to the needs of consumers, and involve consumers in treatment decisions, and in program planning, decision making, and evaluation.

Baseline: Results of studies to date are not consistent.

Data Source/Validity of Data: The SAMHSA Public Managed Care Monitoring and Tracking Project will begin in FY 1998 to systematically assess consumer and family organization satisfaction with their participation in planning, implementing and monitoring MH/SA managed care.

1998 Progress Update:

- C Intensive training was provided for consumer and family representatives who are involved in reviewing Arkansas Medicaid managed care proposals.
- C Assessment of consumer/family involvement in children managed behavioral health care planning indicates general satisfaction in 4 of 10 States intensively studied.

**Measure 4: Release of detailed managed MH/SA quality management and accreditation guidelines by SAMHSA, and use of these guidelines by at least half of the States negotiating Medicaid MH/SA managed care contracts.**

Rationale: There is no agreed-upon standard for quality management of MH/SA managed care systems that the Federal government and States use. This is a problem identified in the GWU studies of Medicaid managed care contracts that may contribute to limited access, consumer grievances, and poor outcomes. NCQA, JCAHO, CARF, COA, and Federal purchasers (DOD, DVA, Medicare) are developing and testing MH/SA managed care accreditation and quality management guidelines.

Data Source/Validity of Data: The Public Managed Care Monitoring and Tracking Project will survey quality management and accreditation standards used by States. The annual GWU legal analysis of Medicaid MH/SA MC contracts will track inclusion of standards in RFPs, contracts, and contract amendments.

1998 Progress Update:

- C The GWU review of Medicaid managed behavioral health care contracts current through the beginning of 1997 found little improvement from the baseline 1995 survey.
- C SAMHSA actively participated with HCFA in developing Quality Improvement Standards for Managed Care

(QISMC), which will be the accreditation standards for Medicare and Medicaid managed care. SAMHSA is jointly developing with HCFA implementation guidelines for QISMC and training programs for State officials and Peer Review Organizations. Training events will be scheduled starting January, 1999.

C The GWU review of Medicaid contracts current through 1998 will assess use of quality management standards. It is not expected that changes will be seen until the 1999 or 2000 surveys.